RESIDENCY PROGRAM HANDBOOK 2014-2015
# TABLE OF CONTENTS

## DEPARTMENT OF OTOLARYNGOLOGY 1-13
- General 6
- Participating Hospitals 7
- Participating Staff 8-10
- Administrative Office Staff 11
- History of the Department 12
- Educational Goals & Objectives of the Program 13

## RESIDENT RESPONSIBILITIES 14-19
- Communications 14
- Referrals 14
- Consultations 14
- Clinics 15
- Billing 16
- Admissions 16
- Orders 16
- Rounds 16
- Progress Notes 16
- Preoperative Notes 17
- Operating Room Scheduling 17
- Operating Room Etiquette 17
- Operative Note 17
- Operative Report Dictation 18
- Operative Experience Record (OER) 19
- Procedure Encounter Form 19
- Death Policies 19
- Discharges 19

## PROGRESSION AND ADVANCEMENT 20-27
- Program Course of Study 20-23
- Organization of the Teaching Services and Clinics
  - Where Residents are Assigned 24-26
- Attending Physician’s Responsibilities 26
- Evaluation and Advancement 27

## EDUCATIONAL GOALS AND OBJECTIVES 28-113

### PGY 2-5 Otolaryngology Sub-specialties Goals and Objectives: 28-63
- Otolaryngic Allergy 29-33
- Head and Neck Oncology 33-39
- Nasal and Paranasal Sinuses 39-43
- Facial Plastic and Reconstructive Surgery 43-50
- Sleep Disordered Breathing 51-54
- Laryngology 54-56
- Otology 56-62
- Otology 62-63
<table>
<thead>
<tr>
<th>EVALUATIONS</th>
<th>126-127</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident Review of Faculty</td>
<td>126</td>
</tr>
<tr>
<td>Faculty Review of Resident</td>
<td>126</td>
</tr>
<tr>
<td>Resident Self Review</td>
<td>126</td>
</tr>
<tr>
<td>Peer Review</td>
<td>126</td>
</tr>
<tr>
<td>Nurses Review of Resident</td>
<td>126</td>
</tr>
<tr>
<td>Administrative Staff Review of Resident</td>
<td>127</td>
</tr>
<tr>
<td>Patient Review of Resident</td>
<td>127</td>
</tr>
<tr>
<td>Resident Review of Program</td>
<td>127</td>
</tr>
<tr>
<td>Faculty Review of Program</td>
<td>127</td>
</tr>
<tr>
<td>Final Written Reviews</td>
<td>127</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>APPENDIX</th>
<th>128-168</th>
</tr>
</thead>
<tbody>
<tr>
<td>POLICIES</td>
<td></td>
</tr>
<tr>
<td>Addressing Concerns in a Confidential and Protected Manner</td>
<td>129-130</td>
</tr>
<tr>
<td>Academic and disciplinary Actions (Probation, Suspension and Dismissal)</td>
<td>131-133</td>
</tr>
<tr>
<td>Duty Hours</td>
<td>134-137</td>
</tr>
<tr>
<td>Includes:</td>
<td>Attestation Form</td>
</tr>
<tr>
<td>Evaluation, Promotion and Termination</td>
<td>138-140</td>
</tr>
<tr>
<td>Handoff Policy</td>
<td>141-142</td>
</tr>
<tr>
<td>Leave:</td>
<td></td>
</tr>
<tr>
<td>Includes:</td>
<td>Vacation</td>
</tr>
<tr>
<td></td>
<td>Interviews</td>
</tr>
<tr>
<td></td>
<td>PGY 5 End of Year Allowance</td>
</tr>
<tr>
<td></td>
<td>Outside Meetings</td>
</tr>
<tr>
<td></td>
<td>Presentations</td>
</tr>
<tr>
<td></td>
<td>General Guidelines</td>
</tr>
<tr>
<td></td>
<td>Sick Leave</td>
</tr>
<tr>
<td></td>
<td>Medical Missions</td>
</tr>
<tr>
<td>Moonlighting</td>
<td>148-150</td>
</tr>
<tr>
<td>Includes:</td>
<td>Request to Participate in Moonlighting Activities Form</td>
</tr>
<tr>
<td>Refill Narcotic Prescriptions</td>
<td>151</td>
</tr>
<tr>
<td>Resident Recruitment, Appointment and Specific Recruitment Criteria</td>
<td>152-156</td>
</tr>
<tr>
<td>Required Additional Study</td>
<td>157</td>
</tr>
<tr>
<td>Resident Research</td>
<td>158-162</td>
</tr>
<tr>
<td>Supervisory Written Lines of Responsibility</td>
<td>163-165</td>
</tr>
<tr>
<td>Includes:</td>
<td>Recognize Resident Fatigue</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MISCELLANEOUS</th>
<th>168</th>
</tr>
</thead>
<tbody>
<tr>
<td>After Hours Parking at ACH</td>
<td>168</td>
</tr>
<tr>
<td>Remote Access to ACH (Meditech)</td>
<td>168</td>
</tr>
</tbody>
</table>
THE DEPARTMENT OF OTOLARYNGOLOGY

General Information:

The Department of Otolaryngology is one of 26 Departments or Divisions of the College of Medicine at UAMS Medical Center (UAMSMC). In Arkansas, UAMSMC is the only medical center providing medical education, clinical care and health-related research for the state.

Our residency program in otolaryngology is committed to providing residents with education in comprehensive medical and surgical care of patients with diseases and disorders that affect the ears, the upper respiratory and upper alimentary systems, and related structures of the head and neck. The program includes core knowledge, skills, and understanding of the basic medical sciences relevant to the head and neck; the upper respiratory and upper alimentary systems; endocrinology; neurology; and the communication sciences, including knowledge of audiology, speech pathology, and audiolingual and speech rehabilitation, as they relate to the head and neck area. The educational program also includes the clinical aspects of diagnosis and the medical and/or surgical therapy for prevention of diseases, neoplasms, deformities, disorders, and/or injuries of the ear, the upper respiratory and upper alimentary systems, the face, the jaw, and other head and neck oncology, and facial plastic and reconstructive surgery.

Three primary teaching hospitals are used including UAMS Medical Center, Central Arkansas Veterans Healthcare System (CAVHS), and Arkansas Children’s Hospital (ACH). These facilities accommodate approximately 40,000 patient admissions and 725,000 outpatient visits annually.

Following the completion of residency training in our department, residents should be prepared to care for patients of all ages with medical and surgical disorders of the ears, the upper respiratory and upper alimentary systems and related structures, and the head and neck; to carry out diagnostic evaluations of patients with otolaryngology disorders; and to carry out surgical and non-surgical management of otolaryngology disorders, including rehabilitation and referral to sub-specialists when appropriate.
PARTICIPATING HOSPITALS

• UAMSMC
The UAMS, Medical Center of Arkansas is a 344-bed acute care facility built in the 1950s. It has been recently remodeled and considerably modernized; a new patient tower has dramatically increased ICU and inpatient beds, as well as completely modernizing the operating rooms. Outpatients are seen in the ENT Clinic on the 3rd Floor of the Jackson T. Stephens Spine and Neurosciences Institute and the 6th Floor of the Arkansas Cancer Research Center, (ACRC). The otolaryngology patient population on this campus shows a cross-section of all areas of otolaryngology problems. UH functions as a Level 1 Trauma center, offering strong training in trauma and reconstruction. In 1989, the ACRC was opened to provide sophisticated evaluation, advanced treatment and rehabilitation for cancer patients, and to participate in the international research effort aimed at solving the cancer problem. This facility was expanded to an 11-floor 175,000 sq. foot facility in October 1996. In addition to our head and neck cancer clinic, prosthetic and speech rehabilitation are among the many services offered by our department at the ACRC.

• Central Arkansas Veterans Healthcare System (CAVHS)
The Central Arkansas Veterans Healthcare System ranks among the busiest VAs in the country. This modern 1505-bed hospital serves a broad range of otolaryngology patients.

This service offers an outstanding experience for resident training and education. Residents rotate at the CAVHS each year. There is full staff coverage in all subspecialties of otolaryngology, including otology/neurotology, facial plastic and reconstructive surgery, head and neck oncologic surgery, endoscopic sinus surgery, skull base surgery, microvascular reconstruction, and endoscopy. Two nurse practitioners help tremendously with coordination of patient care. The outpatient clinics are busy and offer a large volume of patients with a wide variety of clinical problems.

The CAVHS rotation offers the residents an opportunity to exercise some autonomy in managing clinical problems. In addition, the residents have the opportunity to develop some increased responsibility in the operating room. This increased autonomy and responsibility is dependent on the resident’s experience and is done under close staff supervision.

• Arkansas Children’s Hospital (ACH)
Arkansas Children’s Hospital (ACH), established in 1910, is among the top ten pediatric hospitals in the United States treating patients from birth to 21-years of age. It accommodates approximately 70,000 inpatients and 200,000 outpatients per year. The hospital offers primary through tertiary care service in all aspects of pediatric medicine and pediatric subspecialties. The section of pediatric otolaryngology at ACH performs over 2,000 operative cases yearly. Over 10,000 patients are seen in the outpatient otolaryngology clinic.

Presently, ACH has four full-time pediatric otolaryngologists. Our full-time pediatric fellowship was established in 1994. The housestaff consists of two pediatric otolaryngology residents and one fellow on service if the position is filled. Pediatrics residents and medical students rotate on the service, as well.
FACULTY / TEACHING STAFF

James Y. Suen, M.D.
Distinguished Professor and Chairman
Joined the Department: 1974
Residency: University of Arkansas for Medical Sciences
Fellowship: Head and Neck Oncology, M.D. Anderson Cancer Institute in Houston
Practice Specialties: Head and Neck Oncology, Vascular Malformations

J. Michael Key, M.D.
Associate Professor
Joined the Department: July 1986
Residency: University of Arkansas for Medical Sciences
Fellowship: Facial Plastic and Reconstructive Surgery with Dr. Eugene Tardy
Practice Specialties: Facial Plastic and Reconstructive Surgery

Charles M. Bower, M.D.
Professor and Vice Chairman; Chief of Pediatric Otolaryngology at ACH
Joined the Department: July 1990
Residency: University of Arkansas for Medical Sciences
Fellowship: Pediatric Otolaryngology at the Children’s Hospital in Cincinnati with an emphasis in Airway Management
Practice Specialties: Pediatric Otolaryngology, Airway Management

John L. Dornhoffer, M.D.
Professor; Vice Chairman of Adult Services
Joined the Department: July 1994
Residency: University of Arkansas for Medical Sciences
Fellowship: Otology/Neurotology fellowship in Germany and Switzerland
Practice Specialties: Otology/Neurotology

Samuel Welch, M.D., Ph.D.
Associate Professor, Program Director
Joined the Department: January 2001
Residency: University of Arkansas for Medical Sciences
Practice Specialties: Rhinology, Sinus Surgery, Allergy, Sleep Disordered Breathing

Emre Vural, M.D.
Professor
Joined the Department: October 2001
Residency: Ankara University School of Med.
Fellowship: University of Arkansas for Medical Sciences, Department of Otolaryngology
Practice Specialties: Facial Plastic & Reconstructive Surgery, Head and Neck Surgery
Brenden C. Stack, Jr., M.D.
Professor
**Joined the Department:** July 2005
**Residency:** University of South Florida College of Medicine
**Fellowship:** University of Washington School of Medicine
**Practice Specialties:** Thyroid & Parathyroid Surgery, Head & Neck Tumors

Carl Shipp, M.D.
Associate Professor
**Joined the Department:** March 2008
**Residency:** University of Arkansas for Medical Sciences
**Practice Specialties:** General Otolaryngology, Sinus Disorders

Gresham Richter, M.D.
Associate Professor, Vice Chief of Pediatric Otolaryngology at ACH; Pediatric Otolaryngology Fellowship Director
**Joined the Department:** July 2008
**Residency:** University of Arkansas for Medical Sciences
**Fellowship:** Cincinnati Children's Hospital Medical Center, University of Cincinnati
**Practice Specialties:** Pediatric Otolaryngology, Airway Surgery & Vascular Anomalies

Ozlem Tulunay, M.D.
Associate Professor
**Joined the Department:** November 2008
**Residency:** Otolaryngology – Head and Neck Surgery, Medical School of Hacettepe University, Turkey
**Fellowship:** Head and Neck Surgical Oncology, Dept. of Otolaryngology, Wayne State University
**Fellowship:** Laryngology, Vanderbilt University; UCLA; Medical School of Wisconsin and Bastian Voice Institute
**Practice Specialties:** Voice, Airway and Swallowing Disorders, Head & Neck Cancer, Thyroid and Parathyroid Surgery

Mauricio Moreno, M.D.
Assistant Professor
**Joined the Department:** August 2009
**Residency:** General Surgery University of Valparaíso, Chile
**Residency:** Otolaryngology Head & Neck Surgery/University of Chile, Santiago de Chile
**Fellowship:** Head and Neck Surgical Oncology The University of Texas, M. D. Anderson Cancer Center.
**Fellowship:** Microvascular Reconstructive Surgery. The University of Texas, M. D. Anderson Cancer Center.
**Fellowship:** Surgical Endocrinology. The University of Texas, M. D. Anderson Cancer Center.
**Practice Specialties:** Head and Neck Surgery, Thyroid & Parathyroid Surgery, Vascular Anomalies, Head and Neck Microvascular Reconstruction

Larry Hartzell, M.D.
Assistant Professor
**Joined the Department:** July 2012
**Residency:** University of Arkansas for Medical Sciences
**Fellowship:** Arkansas Children’s Hospital
**Practice Specialties:** Pediatric Otolaryngology and Cleft Lip and Palate Surgery
Abby Nolder, M.D.
Assistant Professor, Associate Program Director

**Joined the Department:** September 2012

**Residency:** University of Arkansas for Medical Sciences

**Fellowship:** Children’s Mercy Hospital and Clinics, Kansas City, Missouri

**Practice Specialties:** Pediatric Otolaryngology, Pediatric Airway Management, Sinonasal Disease

Jennings Boyette, M.D.

Assistant Professor

**Joined the Department:** July 2014

**Residency:** University of Arkansas for Medical Sciences

**Fellowship:** Facial plastics and Reconstructive Surgery, Louisiana State University School of Medicine

**Practice Specialties:** Facial Plastics and Reconstructive Surgery

Alyssa Kanaan, M.D.

Instructor

**Joined the Department:** August 2014

**Residency:** American University of Beirut

**Fellowship:** Rhinology/Allergy, University of Pittsburgh Medical Center, Pediatric Otolaryngology, McGill University, Canada

**Practice Specialties:** Rhinology, Allergy & Skull Base Surgery
UAMS Otolaryngology Administrative Office Staff
Jackson T. Stephens Spine & Neurosciences Institute, 9th Floor

### UAMS Administrative Office Staff

<table>
<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Debra Floerchinger</td>
<td>Administrative Assistant</td>
</tr>
<tr>
<td>Sarah Heinz</td>
<td>Medical Students Coordinator &amp; Administrative Assistant</td>
</tr>
<tr>
<td>Angela Jackson</td>
<td>Billing Specialist</td>
</tr>
<tr>
<td>Trudy Lambert</td>
<td>Billing Specialist</td>
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<tr>
<td>Linda Linkous</td>
<td>Billing Specialist</td>
</tr>
<tr>
<td>Tina Moskow</td>
<td>Department Administrator</td>
</tr>
<tr>
<td>Devon Norris</td>
<td>Administrative Assistant</td>
</tr>
<tr>
<td>Stacey Riddling</td>
<td>Residency Coordinator</td>
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<tr>
<td>Beth Seward</td>
<td>Director of Communications</td>
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<tr>
<td>Janet Williams</td>
<td>Purchasing Officer, Reimbursements</td>
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### ACH Administrative Office Staff

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<tr>
<th>Name</th>
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<tr>
<td>Dawn Horn</td>
<td>Fellowship Coordinator &amp; Administrative Assistant</td>
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<tr>
<td>Myra ‘Jo’ McCallie</td>
<td>Administrative Assistant</td>
</tr>
<tr>
<td>Darla Rutledge</td>
<td>Administrative Assistant</td>
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<tr>
<td>Jessica Wright</td>
<td>Administrative Assistant</td>
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### Research Staff

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<tr>
<td>Ekaterina Galanzha, MD, PhD</td>
<td>Research Associate Professor</td>
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<tr>
<td>Yulian Menyaev</td>
<td>Research Associate</td>
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<tr>
<td>Dmitry Nedosekin</td>
<td>Research Associate</td>
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<tr>
<td>Mustafa Sarimollaoglu</td>
<td>Research Associate</td>
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History of the Department

The University of Arkansas for Medical Sciences (UAMS) celebrated its centennial in 1978, and it is the only accredited institution for medical education in Arkansas.

For the first ninety-two years of its existence, the College of Medicine did not have a residency program in otolaryngology. The Division of Otolaryngology was run on a volunteer basis by local otolaryngologists until 1949, when Dr. Frank Forman became the first full-time otolaryngologist to run the service. When Dr. Forman left in 1956, Dr. A.J. Brizzolara took over the service, again on a part-time basis, until 1958. At that time, Dr. H.A. Bailey, Jr., who had been working with the service since 1953, assumed administrative responsibilities and was division chief until 1967. During his tenure, Dr. Bailey was assisted by Drs. Paul Mahoney, Carl Hanchey, E.L. Milner, and Norman Fein, local otolaryngologists who actively participated in clinics, surgeries, and lectures.

The Division of Otolaryngology did not have a full-time chief until 1969, when Dr. Robert McGrew returned to Little Rock and became Chief of the Division. Dr. McGrew worked hard to develop the service and was responsible for initiating the otolaryngology residency program, which was accredited in 1970.

Dr. James Y. Suen was one of the first two residents accepted into the new program, transferring from general surgery. Dr. Suen, an Arkansas native, graduated from UAMS and completed an internship in San Francisco. After finishing the otolaryngology residency, Dr. Suen was the first otolaryngologist accepted into the head and neck fellowship at M.D. Anderson Hospital and Tumor Institute in Houston. After only seven months as a fellow, he was promoted to staff and ran his own service. When he returned to Little Rock in 1974, he took over as head of the Division of Otolaryngology at age 33. Dr. Suen’s innovative work in the field of head and neck cancer quickly brought him to national prominence. Cancer of the Head and Neck, edited by Dr. Suen and Dr. Eugene Myers of Pittsburgh, is now in its fourth edition and has become an internationally-recognized reference source.

“I wanted to build a department that could hold its own with any in the country,” explains Dr. Suen. “Our plan was a simple one…to provide excellent patient care, recruit the best staff available, produce solid, well-trained otolaryngologists, and conduct pertinent, quality research.

“Patients are our highest priority. The multidisciplinary team, of which the faculty and residents are only a part, has been indispensable in accomplishing our goal of comprehensive care for the patient. Since the university did not have funds available to support many of the essential persons on our team, the department has underwritten this expense through professional fees. I want patients to feel that someone cares about them, and that they can obtain the best care available from our team.”

We are proud of our staff, our residents, our team, and their accomplishments. Our goal is to continue to seek excellence, and to preserve those qualities that have brought us this far.
Otolaryngology Residency Program  
Educational Goals and Objectives  
OF THE PROGRAM

The Otolaryngology residency program at the University of Arkansas for Medical Sciences is a university-based program with affiliations with Central Arkansas Veteran’s Hospital and Arkansas Children’s Hospital. The primary goal of the program is to produce physicians who embody the unique knowledge, skills and attitudes of the specialty of Otolaryngology.

Goals of the Program:

1. To prepare competent Otolaryngologist capable of providing comprehensive medical and surgical care for adult and pediatric patients with diseases and disorders that affect the ears, nose and throat, the respiratory and upper alimentary systems, and related structures of the head and neck.
2. To focus on elements related to and required for American Board of Otolaryngology Certification including: Allergy, Facial plastic and reconstructive surgery, Head and Neck Surgery (benign and malignant tumors including the thyroid and parathyroid glands), Laryngology (voice and swallowing disorders), otology/Audiology, Pediatric Otolaryngology, Rhinology (nose and sinus disorders), Neurotology (disorders of the inner ear including tumors) and Sleep Medicine.
3. To promote an environment of inquiry and scholarship, which encourages lifelong learning and the application of new knowledge to practice, consistent with the principles of evidence-based medicine and lifelong education.
4. To maximize the opportunities for residents to balance academic development, service expectations and personal development in an environment that prepares residents for practice in urban or rural settings.

Objectives of the Program:

The Otolaryngology Residency Program will:

1. Maintain full ACGME accreditation for the residency program.
2. Educate physicians who will become board certified in Otolaryngology and maintain certification throughout their careers.
3. Facilitate the preparation of highly qualified Otolaryngologist for practice in a variety of settings.
4. Maintain excellent clinical facilities.
5. Evaluate residents using the ACGME competencies of:
   a. Medical Knowledge
   b. Patient Care
   c. Professionalism
   d. Practice-based Learning and Improvement
   e. Systems-based Practice
   f. Interpersonal and Communication Skills
RESIDENT RESPONSIBILITIES

Communications
A key to successful medical practice is prompt and appropriate communication with patients and their families, attending surgeons and referring physicians. In general, residents are expected to:

- Discuss diagnostic and therapeutic plans and risks with patients and their families.
- Communicate plans and progress of all patients with attending surgeons, including serious problems as they occur, even at night.
- Notify referring physicians upon admission, operation, and discharge of their patients from the hospital.

Referrals
Residents should promptly respond to all requests for patient referral. It is the policy of the Department of Otolaryngology to accept all patients who have, or are suspected of having, an otolaryngology problem, provided that a hospital bed and an attending staff surgeon are available. Patients are not to be screened over the telephone. Residents should promptly contact the appropriate attending surgeon and the hospital transfer team (688-9553), ICU/Intermediate Bed Team (688-2134) or the appropriate clinic to facilitate the referral.

Consultations
Consultations are received via the “Consult Pager,” which is assigned each day to the UAMS MC resident who has the “lightest duty” and is most accessible to take consults. The pager will be passed day to day among the UAMS MC resident team. Consults should be answered promptly to allow continuity in patient care. The chief resident at ACH and the VA should designate one resident to handle and disburse consults. Consults at all hospitals should be sent to the clinics unless the patient is bedfast. Patients on other services must also be charged. It is the attending physician’s responsibility to deliver ALL consult forms to the reimbursement specialist in the office within 24 hours for charging.

The UAMS MC ER has requested that they be in charge of contacting the appropriate resident to take their consult.

- ER Consults
In order to bill consultations received in the Emergency Room an Attending Faculty in Otolaryngology must see the patient. There are no exceptions to this rule. It is the attending physician’s responsibility to deliver ALL consult billing cards to Melissa Pointer’s office in the Otolaryngology Billing Department.
Clinics - General
Residents will be expected to dress in a professional manner at all times; this means no jeans, ties required for men, and equivalent appropriate attire for women. Residents must fill out an Initial Evaluation and Staging form on all new head and neck cancer patients; these forms are available in the clinics.

Clinics - UAMSMC Clinics
- All patients (except for self-pay) seen in the resident clinic must have staff notations and countersignature for billing purposes. Faculty must see patient and document to bill any clinic visit or procedure. (Please see attestation box below).

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<td>Personally Provided</td>
</tr>
<tr>
<td>Resident and TP Involvement</td>
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<td>TP Supervision/Resident Service - No Charge</td>
</tr>
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I certify that the rendering of these professional services and the documentation for the medical record are in accordance with FGP guidelines.

**Signature of Attending:**

*TP – Teaching Physician
*FGP – Faculty Group Practice

- Residents should pursue ward obligations, make pre-op rounds, and attend conferences after all patients have been evaluated at the end of the clinic. However, one resident must remain until all patients have been seen by staff.
- When clinics and surgeries are concurrent, at least one designated resident should be in clinic. All residents not in surgery should be in clinic.

Clinic - Arkansas Children’s Hospital Clinic
- Residents will be primarily responsible for otolaryngologic problems at ACH during working hours.
- Unless previous arrangements have been made, residents will alternate rounding on weekends.
- Residents will dictate all discharge summaries (including those from preceding residents). Residents are also responsible for op notes.

Clinic – Central Arkansas Veterans Healthcare System
- To gain experience in acute and chronic patient care, the PGY3 and PGY4 residents will handle most of the day-to-day care under the supervision of the Chief Resident.
- Every surgical patient will be evaluated by a resident pre-operatively.
- All surgical cases must be cleared by the chief resident.
- PGY3 and PGY4 residents will be responsible for student orientation and instruction on the head and neck exam.
Billing
Professional fees are the lifeblood of this department. In order to bill, a faculty member must be present and appropriate documentation must be given. Without them, there would be no faculty, no staff, and no residency program. Please take the time to accurately and completely fill out encounter forms for UAMSMCMC and ACH patients, including diagnosis.

Please check a diagnosis. If you cannot find a proper code for the condition, please write the condition legibly in the space provided. Each diagnosis code will be reviewed by billing personnel and compared to documentation in the chart to insure the highest level of specificity.

ACH ER billing should be done on the appropriate form at ACH at the time the patient is seen.

Prior Authorization: Please be aware that certain agencies require prior authorizations before they will pay for patient services. If we operate on them (except in emergencies) without this authorization, either the patient will needlessly get stuck with the entire amount of the charge or we will not receive any payment for the service. Rehab requires prior authorization on certain procedures. Voice Rehab requires prior authorization on all procedures, as does Children’s Medical Service, and many private insurance companies are increasingly requiring prior authorization.

Admissions
Nurse practitioners are responsible for scheduling all inpatient admissions with the Admission Department promptly. However, residents should understand how to handle an admission procedure. Special requests for planned post-operative admission (PPOA), for private room, etc., should be indicated.

Orders
Residents and nurse practitioners are responsible for all patient orders including admission, preoperative, postoperative, and discharge orders. Telephone orders must be signed as soon as possible, and no later than 24 hours after ordered. All orders must be dated and timed. Discharge orders should be written on the day prior to the anticipated discharge.

Rounds
Residents are expected to round twice daily. These rounds should endeavor to appropriately incorporate the contribution of attending staff, nurses, and medical students into efficient diagnostic assessment and therapeutic planning for patient care. A computer printout of the service patient census including name, hospital number, diagnosis, date of admission, operative procedure date and description, surgeon, and referring physician should be updated daily.

Progress Notes
Daily notes (dated and timed) should be entered into the progress note section of the chart. Progress notes by medical students should be critiqued and countersigned by a resident. Notes should be brief, but informative about patient condition, planned diagnostic or therapeutic measures, and discharge planning.
**Preoperative Notes**
The resident should review the operative plan with the attending surgeon on the day before the operation. A preoperative note in the progress section of the chart on the day prior to operation should include:

- Preoperative diagnosis/indications
- Planned operation
- Surgeon
- Anesthesia
- Pertinent laboratory data
- Blood/x-ray requests
- Operative risks
- Signed consent

**Operative Room (OR) Scheduling**
Staff physicians or nurse practitioners should schedule all elective patients for operation by 12:00 noon on the day prior to the operation. All data should be listed including patient name, hospital number, age, gender, location, preoperative diagnosis, planned operative procedure(s), and necessary adjuncts such as blood, X-rays, and special instruments or equipment.

**Operating Room (OR) Etiquette**
A resident should be present in the operating room 15 minutes before induction of anesthesia. All anticipated instruments, supplies, and special equipment should be requested of the scrub and circulating nurses. Necessary x-rays and radiological exams are the resident’s responsibility. The entire operative sequence should be briefly reviewed with the scrub nurse. Patient positioning and special anesthetic needs should be reviewed with the anesthesiologist. The roles of the operating surgeon and first and second assistants should be clearly understood. Interpersonal decorum should be maintained at all times.

**Operative Note**
The resident should fill out an operative note (dated and timed) in the progress note section **IMMEDIATELY** following the operation, to include:

- Preoperative diagnosis
- Postoperative diagnosis
- Operation
- Surgeons
- Anesthesia
- Findings
- Complications
- Drains
- Condition
Operative Report Dictation
Residents are asked to dictate the operative report **IMMEDIATELY** after the operation. This ensures proper documentation of the details regarding an operative procedure. A note that the report was dictated (dated, timed, and the job number) should be entered into the progress note of the medical record. **A delay in the dictation of an operative report is unacceptable and will not be tolerated.** The operative report should cover all salient points of the procedure including:

- Patient data
- Preoperative and Postoperative diagnoses
- Operative procedure
- Indication(s) for operation
- Operative findings
- Details of procedure
- Sponge, needle counts, estimated blood loss
- Condition of the patient
- Participation of staff throughout the case

The “Magic Words” for Billing:
- Dr. *(faculty member name)* was present and scrubbed for the entire procedure.
- Dr. *(faculty member name)* performed *(the key portion)* of the procedure
- Dr. *(faculty member name)* was present for the critical and key portions of the case Presence may be documented by anyone but should be dictated in the OP note.

**IMPORTANT POINTS TO REMEMBER:**
Each procedure must be documented in the body of the note. Be as detailed and specific as possible.

The size of the lesions and lacerations should be documented in size of centimeters.

Complex cases need to have total amount of OR time recorded with description of operative field and any extenuating circumstances that made the procedure more difficult or complicated.

Grafts should be recorded by site in square centimeters and location of donor site.
Operative Experience Record (OER)
All surgical encounter forms should include the resident provider number. MCPG’s SMS computer system will track and report by CPT code for each resident to allow completion of the Operative Experience Report at the end of the year. All resident operative experiences are maintained in a database that is offered by the ACGME (Accreditation Council for Graduate Medical Education). The ACGME will assign you a password to access and log your Operative Experience Reports. The ACGME requires all programs to maintain a certain number of OER’s for continued accreditation.

Failure to maintain a proper and up to date OER with the ACGME web-site provided will require you to fill out your OERs on 3x5 cards and return them to the Residency Coordinator at the end of each OR day.

Operative procedures will be reviewed twice a year by the program director. The Program Director will assess the numbers and kinds of operative procedures performed and will discuss his/her findings during semi-evaluations with the residents.

Procedure Encounter Forms
If instructed by the attending staff, residents should fill out appropriate encounter forms in the operating room, or after procedures or consultations, for billing of services.

Death Policies
After the death of a patient, the resident should immediately notify the attending surgeon, next of kin, and the referring physician(s). In addition, a request for organ donation should be made, with the help of the Transplant Coordinator in the hospital, representing the Arkansas Regional Organ Recovery Agency (ARORA). The hospital administrator or nurse supervisor and the chaplain on call should be notified to assist the family with their grief and to arrange for plans for release of the body.

Discharges
Discharge planning should begin when patients are first admitted to the hospital. Appropriate consultation from Social Services, Home Health Care, or Visiting Nurse Associations, etc., should be obtained along with discussions with patients and their families to facilitate discharge to home or extended care facilities at the earliest time compatible with good medical care. Discharge orders should be written on the day prior to discharge. Every effort should be made to have transportation available for patients to leave the hospital on the morning of discharge. All telephone orders and progress notes should be signed, the written note completed, and the discharge summary dictated prior to the patient leaving the hospital. The job number of the dictated discharge summary should be written in the discharge note or order. The referring physician should be contacted by telephone and informed of the patient’s discharge, their discharge medications, and the time of their discharge medications and the time of the follow-up appointment.
OVERVIEW:
Residents/fellows are under supervision of attending faculty physicians who are members of the active medical staff and appropriately credentialed. There are explicit written descriptions of supervisory lines of responsibility for the care of patients developed by the training Program Director and communicated to all residents, and all attending physicians within the program. Residents are supervised in such a way that the resident assumes progressively increasing responsibility according to their level of education, ability and experience. Residents have reliable systems for communication and interaction with supervisory attending physicians. On call schedules for attending physicians are structured to ensure that supervision is readily CAVHS to residents on duty.

DESCRIPTION OF THE PGY-1 YEAR OF OTOLARYNGOLOGY RESIDENCY

Please refer to pages 104-113 under Educational Goals and Objectives

DESCRIPTION OF THE PGY-2 THROUGH PGY-5 YEAR OF OTOLARYNGOLOGY RESIDENCY

PGY2-PGY5 rotations include time at UAMS MC, CAVHS and ACH. Generally there are four residents assigned to UAMS MC each month, including Chief Resident or Acting Chief Resident (PGY4), PGY4, PGY 3 and PGY2 residents. During the ACH rotation there are generally three residents and one Pediatric Otolaryngology Fellow on service. At CAVHS there are three residents assigned, one Chief Resident (PGY5), one PGY4 plus one PGY 2 OR two PGY 3 residents.

During each year, the resident learns the basics of otolaryngology by attending didactic lectures, instructional courses, departmental, regional and national conferences, and participation in AAO-HNS continuing education programs.

PGY 2 Resident

PGY2 Resident spends time at all three affiliated institutions.

The first four weeks of the PGY2 year are spent in an intensive orientation course that helps prepare the resident for inclusion on the clinical service. In the months of May, June and July multiple weekly lectures are given by faculty and ancillary support staff covering topics such as: "Introduction to Head and Neck Cancer", "Facial Trauma", "Rhinology & Sinus", "Ear Disease", "Billing Issues", "Risk Management" and others (a complete listing of resident orientation schedules and conferences is available upon request).

PGY2 Resident Expectations and Progression of Responsibilities are listed below:
1. Under supervision of senior residents and attending staff the PGY2 resident is expected to take an active role in the care of clinic and hospitalized patients. Quality of patient evaluation and care is emphasized.

2. In the operating room the PGY2 resident assists Faculty and senior level residents with more complex surgical procedures as well as personally performs many of the simpler procedures under direct supervision. Experience with basic surgical instruments and their use is obtained in the process.

3. He/she is given no major responsibility for supervision of other residents, and minimal responsibility for medical students.

4. He/she is familiar with in-patients and assists upper level residents in obtaining day-by-day patient information and data.

5. He/she is responsible for maintaining timely and complete medical records.

6. The PGY2 resident attends Faculty clinics and Faculty supervised Resident’s Clinic as assigned by the Chief Resident. Attend Resident Clinic when at UAMS.

7. Becomes familiar with common otolaryngology disorders and begins to acquire skills with diagnosis and management.

8. Performs preoperative history and physical examinations, discusses expected benefits and risks of operative procedures with patients and family. Obtains operative consents for planned surgical procedures.

9. PGY2 Resident begins to take primary at-home call with upper level resident and faculty back-up.

10. Is introduced to research design and preparation through structured conferences. Beginning in July 2012 the PGY 2 residents will be required to complete a patient safety/Quality Improvement project.

11. Is advanced to PGY3 after successful completion of PGY2 clinical and surgical expectations.

PGY3 Resident

The PGY3 resident spends time at all three affiliated institutions.

The PGY3 responsibilities increase in level of complication, medical decision making skills and surgical skill.

PGY3 Resident Expectations and Progression of Responsibilities are listed below:

1. Practices increased supervisory role for patient care, teaching junior residents, and in-patient consultations.

2. May attempt or initiate clinic or bedside procedures, with attending approval and supervision.

3. Takes responsibility for being familiar with patients and serve as a source for day-to-day patient data.

4. Responsible for maintaining timely and accurate medical records.

5. The PGY3 resident spends time in faculty clinic as well as supervised Resident’s Clinic taking more responsibility for work up of outpatients and making care plans for
treatment. He/she takes responsibility for preoperative evaluation of patients, discuss expected benefits and risks of planned procedures and obtaining informed consent.
6. The PGY3 resident begins to work with faculty on unique or existing research projects.
7. The PGY3 resident is expected to perform more advanced otolaryngology cases and may begin to perform more cases as the primary surgeon under supervision.
8. During the second half of the PGY3 year the resident will take responsibility for “Acting Chief” duties at ACH.
9. PGY3 Resident continues to take primary at-home call with upper level resident and faculty back-up.
10. He/she assumes more responsibility for teaching medical students on the rotation as well as junior level residents.
11. Is advanced to PGY4 after successful completion of PGY3 clinical and surgical expectations.

PGY4 Resident

The PGY4 Resident spends time at all three affiliated institutions.

The PGY4 responsibilities increase in level of complication, medical decision making skills and surgical skill.

PGY4 Resident Expectations and Progression of Responsibilities are listed below:

1. Practices increased supervisory role for patient care, teaching junior resident, and in-patient consultations.
2. May attempt or initiate clinic or bedside procedures, with attending approval and supervision.
3. Spends time on designated research rotation developing and performing project under supervision of faculty mentor.
4. Responsible for maintaining timely and accurate medical records.
5. The PGY4 resident spends time in faculty clinic as well as supervised Resident’s Clinic taking more responsibility for work up of outpatients and making care plans for treatment. He/she takes responsibility for preoperative evaluation of patients, discuss expected benefits and risks of planned procedures and obtaining informed consent.
6. The PGY4 resident is expected to perform more advanced otolaryngology cases and may begin to perform more cases as the primary surgeon under supervision.
7. During the first half of the academic year at ACH and during the second half of the academic year at UAMS MC the PGY4 resident assumes the role of “Acting Chief Resident”.
8. PGY4 Resident continues to take primary at-home call with upper level resident and faculty back-up. The resident progresses to take secondary (back up) call when assuming Acting Chief Resident responsibilities at UAMS MC.
9. Takes increasing responsibility for medical student education as well as teaching junior level residents.
10. Spends two months on the Otology rotation seeing otology patients in clinic (both UAMS Otology and ACH Otology) and assisting with surgical procedures performed by neurotology faculty. As skills progress begins to perform level appropriate procedures as operative surgeon.

11. Is advanced to PGY5 after successful completion of PGY4 clinical and surgical expectations.

**PGY5 Resident**

The PGY5 resident spends time at all three affiliated institutions.

The PGY5 responsibilities increase in level of complication, medical decision making skills and surgical skill.

**PGY5 Resident Expectations and Progression of Responsibilities are listed below:**

1. The PGY5 Resident acts as chief resident throughout the course of this last year of training.
2. Assumes responsibility for coordinating the service at each respective hospital and is given more autonomy (still under faculty supervision) in case management.
3. There are additional administrative and program responsibilities for the chief resident which include, but are not limited to, assistance with preparation of rotation schedules, preparation of call schedules, coordination of journal club article assignments, and increased responsibility for training younger residents. When chief at UAMS the Resident Clinic responsibility includes but not limited to the following: administration, scheduling, and primary patient care under the supervision of ENT attendings.
4. All aspects of case management and surgical care for otolaryngology are exercised at this level of training.
5. PGY5 residents continue to participate in research activities as in the PGY3-4 years.
6. PGY5 residents work in clinics at all three affiliated institutions (during Otology rotation at ACH).
7. Spends two months on the Otology rotation seeing otology patients in clinic (both UAMS Otology and ACH Otology) and assisting with surgical procedures performed by neurotology faculty. As skills progress begins to perform level appropriate procedures as operative surgeon.
8. When PGY5 residents are assigned call it is as back-up (2nd call) during the chief year.
ORGANIZATION OF THE TEACHING SERVICE(s) AND CLINIC(s) WHERE RESIDENTS ARE ASSIGNED

UAMS MEDICAL CENTER (UAMS MC)

Program Requirements and Duties - UAMSMC
Residents on the UAMSMC otolaryngology rotation gain clinical, surgical, and case management knowledge for adult patients in several areas including head and neck oncology, skull base surgery, thyroid, sinus disease, allergy, trauma, facial plastic and reconstructive surgery, otology/neurotology, sleep disordered breathing, Otolaryngic allergy, voice, general ENT, laser and endoscopy. Four residents rotate at UAMSMC each month. The chief resident spends the majority of time in the OR, and has primary responsibility for the UAMS Resident Clinic with mid to lower level residents rotating between the OR and clinical coverage as assigned by the Chief or Acting Chief Resident. Otolaryngology residents are responsible for the patients in clinics, patients in the OR and in-patient care and consults. Residents are 100% under the direction of a staff physician at all times regarding patient care.

Program Requirements and Duties - UAMSMC Otology Rotation (PGY4 and PGY5)
The rotation is supervised by our Neurotologist (Dr. John Dornhoffer) who works at both ACH and UAMSMC. Likewise, the Otology resident spends a portion of his/her time each week at both affiliated hospitals.

While rotating at UAMSMC this resident works solely with Dr. Dornhoffer seeing patients in his clinic. As the resident becomes more skilled and proficient with otology he/she begins to see patients in the Resident Otology Clinic. Plans for care are discussed with the attending as indicated and any otologic surgeries are staffed by Dr. Dornhoffer.

The Otology Resident attends the monthly UAMSMC Neurotology Conference and is responsible for some of the didactic material presented at this conference. Refer to the Otology Rotation Goals and Objectives in the Appendix of the Program Information Form.

The Otology Resident gains clinical, surgical and case management knowledge in several areas during this rotation: hearing and vestibular disorders, middle ear surgery, skull base procedures, hearing rehabilitation, vestibular rehabilitation, cochlear implants and implantable hearing aids.

ARKANSAS CHILDREN’S HOSPITAL (ACH)

Program Requirements and Duties - ACH
Residents on the pediatric otolaryngology rotation at Arkansas Children’s Hospital are provided a comprehensive education in medical and surgical care of patients with disease and disorders that affect the ears, the upper respiratory and upper alimentary systems and related structures of the head and neck, in the pediatric age group.

Presently, ACH has five full-time pediatric otolaryngologists and two part time pediatric otolaryngology surgeons. Our pediatric fellowship was established in 1994. Our hope is that this program will attain ACGME Accreditation in the near future. The housestaff consists of three
pediatric otolaryngology residents and one fellow on service. The mid level resident at ACH acts as the “ACH chief resident”. The ACH chief resident has primary responsibility for managing ACH clinic, OR, consults and rounds.

The resident gains clinical, surgical, and case management knowledge for pediatric patients in several areas during this rotation: general ENT, airway management, airway reconstruction, cleft lip and palate, sinus disease, allergy, trauma, facial plastic and reconstructive surgery, otology/neurotology, laser surgery, endoscopy and voice disorders. Otolaryngology residents are responsible for patients in clinics, patients in the OR and in-patient care. Residents are 100% under the direction of a staff physician at all times regarding patient care.

In addition to the general program requirements listed above the ACH Otolaryngology Service offers monthly specialty conferences that cover a variety of topics in pediatric ENT. Patients are also reviewed during these weekly conferences. Monthly conferences may be replace by a formal lecture at times by a specialist in another but related pediatric arena. Also, every month residents and fellows also participate in a multidisciplinary conference know as the Arkansas Pediatric Aerodigestive Center. including, among other topics, cleft lip/palate and vascular malformations.

Program Requirements and Duties – ACH Otology Rotation (PGY4 and PGY5)

The rotation is supervised by our Neurotologist (Dr. John Dornhoffer) who works at both ACH and UAMSMC. Likewise, the Otology resident spends a portion of his/her time each week at both affiliated hospitals. The resident assigned to the Otology rotation has primary responsibility for the Otology patients on these two services.

While rotating at ACH, this resident communicates with the mid level resident and/or ACH staff and if finished with daily Otology duties becomes available as needed to assists with Pediatric Otolaryngology consults, rounds, and other O.R. duties.

The Otology Resident attends the monthly UAMSMC Neurotology Conference and is responsible for some of the didactic material presented at this conference. Refer to the Otology Rotation Goals and Objectives in the Appendix of the Program Information Form.

The Otology Resident gains clinical, surgical and case management knowledge in several areas during this rotation: hearing and vestibular disorders, middle ear surgery, skull base procedures, hearing rehabilitation, vestibular rehabilitation, cochlear implants and implantable hearing aids.

CENTRAL ARKANSAS VETERANS HEALTHCARE SYSTEM - CAVHS HOSPITAL

Residents gain clinical, surgical, and case management knowledge and skills for adult patients including head and neck cancer, skull base, thyroid, sinus/rhinology, trauma, facial plastics/reconstructive, otology/neurotology, sleep disordered breathing, voice, general ENT, laser, and endoscopy.
While all CAVHS resident care is closely supervised, the VA rotation offers the residents an opportunity to exercise more autonomy in managing patient care, administrating clinics and scheduling surgeries. While on Service the resident interfaces with providers in primary care, audiology, speech pathology, radiology, pathology, medical and radiation oncology, and other medicine and surgical specialties. This is a particularly valuable experience for the Chief Resident as the Service most closely resembles the structure of a private otolaryngology practice than any other offered during their training.

Program Requirements and Duties – CAVHS

The PGY2 residents time is devoted to patient care in clinics as well as OR cases appropriate for level of training. They participate with upper level residents in care of hospitalized patients as well as in-patient consult evaluations.

The PGY3 resident is also responsible for in-patient care. They take an increasingly larger role in the operation room doing cases that require more skill and judgment. They also take a larger role in the clinic and are expected to manage level appropriate clinical problems.

The PGY4 resident performs essentially the same functions as the PGY3 resident. Roles in the clinic and operating rooms increase over the PGY3 level commensurate with skill.

The PGY5 resident is Chief Resident and administrates the service and assists faculty in supervising the wards. In consult with the staff, they make most decisions of overall patient management. They perform the more complex operative procedures with staff supervision. They see clinic patients and are responsible for clinic administration oversight and are responsible for reviewing all surgical cases preoperatively.

Attending Physician’s Responsibilities

The attending physician is expected to see every patient within 24 hours of admission. He/she is to write a note describing and confirming the patient’s history, examination, problem and the diagnostic and therapeutic plans. The attending physician is also encouraged to discuss topics relevant to the patients on the service with the students, interns, and residents. The attending physician is to see every patient on the service daily and to write a daily progress note. The attending must take responsibility to ensure that all of the clinical decisions made on the patient are appropriate. Faculty foster residents on how to arrive at clinical decisions, and as resident competence is proven, the resident is given the opportunity to make supervised clinical decisions. He or she must be certain that therapy is appropriate, that diagnostic studies and particularly invasive procedures are necessary, cost-effective and efficient, and that high quality care is provided. It is the responsibility of the residents and fellows to write patient care orders. "Do Not Resuscitate," "Comfort Care," or "Withdrawal of Cardiopulmonary Support" orders must be countersigned according to hospital policy ML.3.03 Care of Hopeless/Moribund Patients. The attending also has an obligation to provide high quality instruction in diagnosis, treatment and pathophysiology to both the residents and students on the service. Clinical rounds must be balanced into both work rounds and teaching rounds at the bedside.
Evaluation and Advancement
In compliance with the UAMSMC College of Medicine GME Committee policy on Evaluation and Promotion, the following provisions apply: The training program develops physicians clinically competent in the field. Clinical competence requires: a solid fund of basic and clinical science knowledge a solid fund of knowledge of the healthcare system the ability to perform an adequate history and physical examination the ability to appropriately order and interpret diagnostic tests adequate technical skills to perform selected diagnostic and therapeutic procedures clinical judgment to critically apply the above data to individual patients and patient populations ethical behavior and professional attitudes, including appropriate interpersonal interactions with patients, professional colleagues, supervisory faculty and all paramedical personnel personal integrity which includes strict avoidance of substance abuse, theft and unexcused absences regular and timely attendance at the educational activities of the training program Each of the above elements of clinical competence is assessed on a regular basis by direct faculty supervisors with subsequent review by the Program Director. Evaluation by peer resident physicians, nursing staff and other paramedical staff are included at less frequent intervals. Each resident meets with the Program Director at least twice a year to review evaluations, in-service scores, clinical evaluation exercises and other assessments. Advancement to the subsequent year of training with greater involvement and independence in specific patient care activities requires satisfactory ratings on these evaluations per the protocol in the training program. In each year of training, responsibility for patient care must increase. This increased responsibility is drawn from many different facets in the residency training process and includes clinical training and teaching responsibilities to the less experienced members of the team. The resident, in addition to regular physician duties and a responsibility to continue education, manages the patient care team and reports to the attending faculty physician.

The OTO/HNS Faculty semi-annually (December/June) reviews residents, both subjectively and objectively, as they progress through the training program. Each faculty is required to complete an evaluation form on each resident, which they access through the New Innovations Residency Management Suite. When all evaluations have been completed, the residency coordinator accesses the New Innovations System to complete a summarization of each resident’s evaluation. Confidentially, each otolaryngology resident will meet formally with the Residency Director and / or the Program Chairman. There the resident is given the opportunity to review his evaluation and ask any questions regarding concerns the Residency Director or Chairman might have. The resident is also given the opportunity at this time to express any concerns he/she might have with the program, faculty, or department in general. Upon completion of the resident’s review, the Residency Director will complete a summary sheet of the review between the resident, Residency Director and Chairman. Upon completion of the chief resident’s review, the Residency Director will dictate a summary and make a statement as to whether the chief resident is ready to be released without faculty supervision. Chief resident summaries are then transcribed by the residency coordinator and placed in the chief resident’s permanent file.
Competency-Based Goals and Objectives

PGY 2 – 5 Years
Otolaryngology Sub-specialties

Otolaryngic Allergy

Head and Neck Oncology

Nasal and Paranasal Sinuses

Facial Plastic and Reconstructive Surgery

Sleep Disordered Breathing

Voice and Swallowing

Otology

Geriatric
Otolaryngic Allergy: Goals and Objectives

Introduction
The resident is expected to obtain sufficient knowledge to diagnose and treat allergy related disorders of the upper respiratory tract.

The resident is expected to gain this knowledge by reading appropriate textbooks, attending lectures given by faculty, participating in Grand Rounds and Journal Clubs, attending in-house hands-on courses and performing supervised patient evaluations in the outpatient setting.

The resident is expected to learn and gain practical hands-on experience with otolaryngic allergy testing and treatment techniques in the clinical setting.

It is expected that as the resident obtains experience and knowledge of otolaryngic allergy diagnosis and management that he/she will be given, in a graduated manner, responsibility for care of the allergy patient and in a similar manner will help teach and supervise lower level residents as they attempt to learn.

Curriculum

Specific Reading Assignments

Allergy in ENT Practice: The Basic Guide, King, et al, 2005
Food Allergy, Trevino, et al, 1997

Goals

Cognitive Goals:

1. Learn the history and evolution of Otolaryngic Allergy.
2. Learn basic immunology related to allergic etiology and symptomatology.
3. Learn concepts, specific etiologies and symptomatology of seasonal and perennial allergies.
4. Learn theory and principles of food related allergy, etiology and diagnosis.
5. Expand knowledge about medications useful for the treatment of allergy, their indications, contraindications, appropriate dosing and side effects.
6. Learn principles, techniques and indications for testing the suspected allergic patient.
7. Learn clinical indications for and techniques for immunotherapy.
8. Learn the signs, symptoms and treatment of anaphylaxis.

Non-Cognitive Goals:

1. Obtain Comprehensive understanding and appreciation of the role of practice based learning in Otolaryngology.
2. Obtain comprehensive understanding and appreciation of the role of professionalism in Otolaryngology.
3. Gain skills of interpersonal communication with patients, peers and staff.

**Technical Goals:**
(ACGME Goals: Medical Knowledge, Patient Care)
1. Learn to interpret symptoms and physical signs of inhalant allergy.
2. Learn techniques for inhalant allergy testing.
3. Learn application of avoidance and medical management for inhalant allergy.
4. Learn methods for diagnosis and treatment of fixed and cyclic food allergy.
5. Learn techniques necessary for providing immunotherapy.

**Objectives/Cognitive**

**Objectives for Cognitive Goal 1:**
Learn the history and evolution of Otolaryngic Allergy.
1. Develop an understanding of how otolaryngic allergy testing and treatment methods evolved in relation to experiential clinical knowledge and evidence-based research.
2. Understand the methods of testing and treatment of allergies by the otolaryngology community and how they compare and differ from the methods of the General Allergy community.

**Objectives for Cognitive Goal 2:**
Learn basic immunology related to allergic etiology and symptomatology.
1. Exhibit an understanding of basic immunology related to the Gel and Coombs Classification with emphasis on Type I (IgE mediated) and Type III (Immune complex mediated) immunologic responses.
2. Exhibit knowledge of cellular and chemically mediated responses and their affect on symptom production.
3. Develop understanding of the principle of “total allergic load”.

**Objectives for Cognitive Goal 3:**
Learn concepts, specific etiologies and symptomatology of seasonal and perennial allergies.
1. Become familiar with seasonal allergens, their classification, and timing of pollination/prevalence.
2. Become familiar with local and regional environmental factors affecting antigenicity and potency of allergens.
3. Understand the multiple etiologies of perennial allergies.
4. Learn common allergic symptoms related to the ears, nose, mouth and throat and the head and neck region in general.

**Objectives for Cognitive Goal 4:**
Learn theory and principles of food related allergy, etiology and diagnosis.
1. Exhibit an understanding of fixed ("anaphylactic") food allergy, its causes and symptoms.
2. Exhibit an understanding of cyclic ("delayed") food allergy, its causes and symptoms.

Objectives for Cognitive Goal 5:
Expand knowledge about medications useful for the treatment of allergy, their indications, contraindications, appropriate dosing and side effects.

1. Become familiar with the proper patient selection, use and dosing of antihistamines, decongestants, mucolytics/expectorants, corticosteroids (oral and topical), leukotriene inhibitors, and other “allergy” medications.
2. Understand potential side effects and contraindications of allergy medications.

Objectives for Cognitive Goal 6:
Learn principles, techniques and indications for testing the suspected allergic patient.

1. Exhibit knowledge and understanding of allergy testing principles as they relate to skin reactivity (erythema and whealing) to allergens when applied topically, by prick method, intradermal injection and progressive dilutional testing.
2. Gain knowledge of different testing techniques including skin testing and in-vitro testing and the applications of each.
3. Understand indications for testing the suspected allergy patient and the indications and contraindications of specific testing techniques.

Objectives for Cognitive Goal 7:
Learn clinical indications for and immunomodulation principles of immunotherapy.

1. Exhibit understanding of when to recommend immunotherapy to the allergy patient.
2. Exhibit understanding of how immunotherapy affects the patient’s immune system and how it results in symptom control.

Objectives for Cognitive Goal 8:
Learn the signs, symptoms and treatment anaphylaxis.

1. Develop knowledge of the physical signs and symptoms of anaphylaxis and be able to differentiate them from those of the vasovagal reaction.
2. Develop knowledge of basic and advanced treatment methods for anaphylaxis.

Objectives/Non-Cognitive

Objectives for Non-Cognitive Goal 1:
Obtain Comprehensive understanding and appreciation of the role of practice based learning in Otolaryngology.
1. Be able to skillfully use scientific evidence and methods to investigate, evaluate and improve patient care practices.

**Objectives for Non-Cognitive Goal 2:**
Obtain comprehensive understanding and appreciation of the role of professionalism in Otolaryngology.

1. Develop leadership and behavioral skills that reflect commitment to continuous professional development, ethical practice, understanding and sensitivity to diversity and responsible attitude toward patients and society.

**Objectives for Non-Cognitive Goal 3:**
Gain skills of interpersonal communication with patients, peers and staff.

1. Develop and display leadership and interpersonal communications skills that result in and maintain professionalism with patients, families, peers and staff.

### Objectives/Technical

**Objectives for Technical Goal 1:**
Learn to interpret symptoms and physical signs of inhalant allergy.

1. Develop basic and advanced history skills in order to recognize the common symptoms of otolaryngic allergy.
2. Develop basic and advanced physical exam techniques to recognize common physical signs of otolaryngic allergy.

**Objectives for Technical Goal 2:**
Learn techniques for inhalant allergy testing

1. Gain practical experience with basic skin testing techniques and interpretation by observing and performing prick, intradermal and dilutional techniques in the clinic and laboratory setting.
2. Learn in-vitro testing techniques (with emphasis on RAST-type) and be able to interpret results.
3. Apply knowledge of etiologic factors of inhalant allergy to techniques of environmental control and avoidance measures.

**Objectives for Technical Goal 3:**
Learn application of avoidance and medical management for inhalant allergies.

1. Understand and recommend allergy avoidance measures, including environmental controls measures, for the treatment of inhalant allergies.

**Objectives for Technical Goal 4:**
Learn methods for diagnosis and treatment of fixed and cyclic food allergy.
1. Recognize methods of diagnosing fixed food allergies to include detailed history and in-vitro testing for IgE mediated reactions and principles of avoidance.
2. Recognize the major steps in the food allergy “cycle” and be able to apply them in the clinical setting.
3. Be able to utilize the Elimination/Challenge test for the diagnosis of cyclic food allergy in the clinical setting.
4. Understand and be able to apply use of the Rotary Diversified diet in the management of cyclic food allergies.

Objective for Technical Goal 5:
Learn techniques necessary for providing immunotherapy.

1. Apply skin and in-vitro testing results for application to immunotherapy treatment.
2. Prepare skin testing treatment boards.
4. Perform and interpret vial tests.
5. Administer allergy shots to patients.
6. Manage immunotherapy dose escalation.
7. Understand maintenance immunotherapy.
8. Understand problem solving during immunotherapy.
9. Attend didactic and Hands-on otolaryngic allergy courses as possible.

**Head and Neck Oncology – Goals and Objectives**

**Introduction**

The fundamental focus of the head and neck oncology experience on the UAMS rotation is an expanded clinical experience and depth in diagnosis and treatment of oncologic head and neck conditions. Principles of diagnosis, staging and treatment are taught progressively and continuity of care is emphasized. This subspecialty focus of the rotation provides residents with an in-depth experience in the diagnosis and management of head and neck neoplasms.

The otolaryngology resident will be constantly supervised by the attending staff, which has clinical expertise in head and neck oncology. When more senior residents are present on the service a hierarchical system will prevail, with the junior resident reporting to the senior resident or chief resident of the surgical team, who in turn reports to the attending staff. It is expected that, until delegated more authority, the junior resident will discuss all issues with the chief resident or attending staff. Senior residents and attending surgical staff will be available in a rapid reliable manner. Delegation of authority and responsibility for patient care will increase as the resident demonstrates increased competence in the delivery of safe, effective, and compassionate care. The head and neck staff will formally evaluate each otolaryngology trainee’s performance at the end of the UAMS rotation.
Curriculum

Reading Assignments:
*Home Study Course* by the American Academy of Otolaryngology
Select peer review articles from Otolaryngology journals

Supplemental Reading:
Cancer of the Head & Neck by Meyers and Suen
Atlas of Head and Neck Surgery by Lore and Medina
Head and Neck Pathology with Clinical Correlation by Wenig

Products
1. Required submission of tests from the *Home Study Course*
2. Oral presentation of interesting head and neck cases as they present to the oncology clinic
3. Oral presentation of new and recurrent head and neck cancer patients at the weekly multidisciplinary head and neck tumor conference

Conferences
1. Multidisciplinary Head and Neck Tumor Conference - Weekly
2. Morbidity and Mortality Conference – 2 times per month

Goals

**Cognitive Goals**
*(ACGME Goals: Medical Knowledge, Patient Care, & System-Based Learning)*

1. Increase skill in performing the general and targeted head and neck history and review.
2. Develop an intermediate to advanced level of knowledge of the analysis of preoperative risk factors that influence perioperative and intraoperative management of oncology patients.
3. Increase skill in performing the head and neck examination.
4. Increase skill in presenting new and established oncology patients in a concise and focused manner.
5. Develop an intermediate to advanced level of knowledge of the surgical anatomy and physiology of head and neck neoplasia.
6. Increase knowledge of speech, digestive, and physical rehabilitative options for oncology patients.
7. Develop an intermediate to advanced knowledge of the surgical, radiological, immunological, and chemotherapeutic options that are available for the treatment of head and neck neoplasia.

**Non-Cognitive Goals**
*(ACGME Goals: Interpersonal/Communication, Professionalism, Practice-based Learning)*
1. Develop an understanding of the significant psychosocial, economic and physical stresses and their manifestations that life-threatening conditions have on patients and their families.

2. Develop an understanding of professional practice in a specialty hospital environment, including an appreciation of the different styles of interacting with head and neck cancer patients and their families.

3. Develop skills in managing the psychosocial aspects of head and neck oncology patient care.

**Technical Goals**

*ACGME Goals: Medical Knowledge, Patient Care, & System-Based Learning*

Gain additional experience in a wide range of head and neck oncological procedures.

2. Obtain an intermediate level of skill in head and neck oncological procedures.

**Objectives/Cognitive**

**Objective for Cognitive Goal 1:**
Increase skill in performing the general and targeted head and neck history and review.

1. Be able to describe the elements of a complete and targeted head and neck history including the patient’s:
   a. Chief complaint
   b. Current illness history
   c. Allergies
   d. Medications
   e. Previous surgeries
   f. Pertinent social history and cultural background

2. Be able to review systems, emphasizing systemic conditions that may affect the head and neck.

3. Be able to efficiently conduct a complete and targeted head and neck history and systems review.

4. Be able to describe the elements of a complete head and neck oncology specialty outpatient clinical note.

**Objective for Cognitive Goal 2:**
Develop an intermediate to advanced level of knowledge of the analysis of preoperative risk factors that influence perioperative and intraoperative management of oncology patients.

1. Be able to outline the expected perioperative course for common head and neck procedures (listed in Objective for Cognitive Goal 8) and the indicators of potential complications that arise in the perioperative period.

2. Be able to describe the nutritional assessment and nutritional support of head and neck cancer patients.

3. Be able to demonstrate an understanding of the management of perioperative patients in the intensive care unit including fluids, electrolytes, hemodynamic stability and ventilator management.
4. Be able to describe the incidence, identification, and management of potential complications associated with head and neck oncology patient care including:
   a. Fistula
   b. Facial paralysis
   c. Dysphagia
   d. Chronic Pain
   e. Aspiration
   f. Aphonia
   g. Bleeding and carotid rupture
   h. Esophageal stenosis
   i. Mucositis
   j. Shoulder weakness
   k. Hypocalcemia and hypothyroidism

Objective for Cognitive Goal 3:
Increase skill in performing the head and neck examination.

1. Increase skill in using the fiberoptic and rigid laryngoscope.
2. Increase skill in performing mirror examination of the larynx.
3. Increase skill in physical examination of the head and neck.
4. Be able to describe the common and uncommon anomalies and conditions that may be encountered in the head and neck exam.

Objective for Cognitive Goal 4:
Increase skill in presenting new and established oncology patients in a concise and focused manner.

1. Be able to consistently present the patient’s history and the pertinent physical findings, putative diagnosis, and proposed management plan to staff in a concise and organized way.

Objective for Cognitive Goal 5:
Develop an intermediate to advanced level of knowledge of the surgical anatomy and physiology of head and neck neoplasia.

1. Be able to describe the TNM staging system for all head and neck locations.
2. Be able to describe and draw the anatomy of the larynx.
3. Be able to describe the development of the larynx with implications of tumor spread.
4. Be able to describe and draw the fascial spaces of the neck.
5. Be able to describe the current theory of cancer genetics.
6. Be able to describe the advantages and disadvantages of fine needle aspiration of head and neck masses.
7. Be able to describe the anatomy of the skull base and the various syndromes that are associated with tumor invasion of motor and sensory nerves.
8. Describe the most common lymphatic drainage basins for all the anatomic subsites.
9. Describe the five-year survival rates for various tumors and locations.
Objective for Cognitive Goal 6:
Increase knowledge of speech, digestive, and physical rehabilitative options for oncology patients.

1. Be able to describe the options and process of communicative and digestive rehabilitation after procedures that disrupt or remove oral, pharyngeal or laryngeal structures.
2. Be able to describe options for speech in patients with tracheostomies.
3. Describe the indications for physical rehabilitation in head and neck oncology patients.

Objective for Cognitive Goal 7:
Develop an intermediate to advanced knowledge of the surgical, imaging/radiological, immunological, and chemotherapeutic options that are available for the diagnosis and treatment of head and neck neoplasia.

1. Be able to identify important features and landmarks of head and neck studies:
   a. Axial/coronal CT scan
   b. T1/T2 MRI
   c. Ultrasound
   d. PET imaging
   e. Angiography
   f. Lymphoscintigraphy
   g. Sentinel node biopsy
   h. Barium swallow and MBS
2. Be able to describe the natural history, clinical presentation, evaluation, and general options for treatment of the following malignancies:
   a. Non-squamous cell cancers of the head and neck
   b. Skin cancers
   c. Nasopharyngeal carcinoma
   d. Sinonasal carcinoma
   e. Oral cavity carcinoma
   f. Oropharyngeal carcinoma
   g. Hypopharyngeal carcinoma
   h. Laryngeal carcinoma
   i. Esophageal carcinoma
   j. Thyroid and parathyroid cancers
   k. Cervical metastases

Objective/Non-Cognitive
Objective for Non-Cognitive Goal 1:
Develop an understanding of the significant psychosocial, economic and physical stresses and their manifestations that life-threatening conditions have on patients and their families.
1. Be able to describe a variety of coping reactions that are commonly employed by patients with life threatening illnesses.
2. Be able to describe an appropriate therapeutic response for each of the common coping reactions that are employed by patients with life-threatening illnesses.
3. Demonstrate an understanding of how patients’ economic concerns may impact their decision making and compliance.
4. Be able to describe physical stresses that may impact a patient’s social environment.

Objective for Non-Cognitive Goal 2:
Develop an understanding of professional practice in a specialty hospital environment, including an appreciation of the different styles of interacting with head and neck cancer patients and their families.

1. Be able to demonstrate an appropriate approach to the evaluation of oncology patients in the specialty clinic environment.
2. Be able to describe appropriate responses to various levels of patient inquiries, comprehension and participation in their disease process.

Objective for Non-Cognitive Goal 3:
Develop skills in managing the psychosocial aspects of head and neck oncology patient care.

1. Be able to describe the ethical issues that are involved in the treatment of patients with life-threatening illnesses.
2. Be able to effectively communicate with patients and their families.

Objective/Technical

Objective for Technical Goal 1:
Gain additional experience in a wide range of head and neck oncological procedures.
1. Obtain experience in the design and transfer of myocutaneous flaps.
2. Gain experience in the design, harvest and inset of microvascular flaps.
3. Gain experience in the design and reconstruction of soft tissue and osseous defects.
4. Gain experience in surgical rehabilitation of the voice, including tracheoesophageal puncture.

Objective for Technical Goal 2:
Obtain an intermediate level of skill in head and neck oncological procedures.

1. Be able to appropriately plan and mark surgical incisions.
2. Be able to technically raise surgical flaps.
3. Be able to safely and efficiently perform a tracheostomy.
4. Be able to appropriately select and close surgical defects using local and regional flaps.
5. Be able to safely and appropriately complete the majority of surgical oncologic operations, including
a. Composite resection of the oral cavity tumors
b. Neck dissections
c. Cricopharyngeal myotomy
d. Pharyngectomy
e. Pharyngotomy
f. Maxillectomy
g. Partial and total glossectomy
h. Partial and total laryngectomy
i. Thyroidectomy
j. Parathyroidectomy
k. Parotidectomy

### Nasal and Paranasal Sinuses – Goals and Objectives

#### Introduction

The resident is expected to obtain sufficient knowledge to diagnose disorders of and to gain in depth experience with medical treatment and surgical management for disorders the nasal cavity, paranasal sinuses and related structures. Such knowledge will include nasal and paranasal sinus anatomy and variations, physiology of normal function and that of disease states, proper evaluation of symptomatology and advanced in depth knowledge of medical and surgical treatment options for related diseases. (NOTE: Allergic diseases of the upper respiratory tract is taught as a separate module)

The resident is expected to gain this knowledge by reading appropriate textbooks, attending lectures given by faculty, participating in Grand Rounds and Journal Clubs, performing supervised patient evaluations in the outpatient setting and, when appropriate, assist and perform surgical procedures indicated for the treatment of the related group of disorders. Bi-annual in-house sinus courses will complement the learning experience.

It is expected that as the resident obtains experience and knowledge related to the diagnosis and management of nasal and paranasal sinus disorders that he/she will be given, in a graduated manner, responsibility for care of affected patients and in a similar manner will help teach and supervise lower level residents as they attempt to learn.

#### Curriculum

**Specific Reading Assignments**


#### Goals

**Cognitive Goals:**

*(ACGME Goals: Medical Knowledge, Patient Care & System Based Learning)*

1. Expand understanding of the evaluation and management of patients with
nasal and sinus disease.
2. Expand knowledge about medical (non-surgical) options for management of patients with nasal and sinus disease.
3. Learn surgical options for management of nasal and sinus disorders, including indications, contraindications, risks and expected outcomes.
4. Learn perioperative management of patients with nasal and sinus disease.

Non-Cognitive Goals:
(ACGME Goals: Interpersonal/Communication, Professionalism, Practice-based learning)
1. Obtain Comprehensive understanding and appreciation of the role of practice based learning in Otolaryngology.
2. Obtain comprehensive understanding and appreciation of the role of professionalism in Otolaryngology.
3. Gain skills of interpersonal communication with patients, peers and staff.

Technical Goals:
(ACGME Goals: Medical Knowledge, Patient Care)
1. Learn skills for proper evaluation of the patient with nasal and sinus disease.
2. Learn skills for radiographic evaluation and interpretation of related disorders.
3. Learn skills for medical management of the nasal/sinus patient.
4. Learn skills for surgical techniques related to nasal and sinus disorders.
5. Learn skills for perioperative management of the nasal/sinus patient.

Objectives/Cognitive

Objectives for Cognitive Goal 1:
Expand understanding of the evaluation and management of patients with nasal/sinus disease (NSD).

Be able to recognize the symptoms and physical signs in the NSD patient.
Be able to analyze physical findings and their implications in the NSD patient.
Be able to apply physical findings and utilize appropriate diagnostic studies in the NSD patient in order to make appropriate medical or surgical treatment recommendations.

Objectives for Cognitive Goal 2:
Expand knowledge about medical and non-surgical options for management of Patients with NSD.

1. Understand medical options for managing NSD including proper indications for use of antibiotics, antihistamines, decongestants, mucolytics, corticosteroids and other medications useful for treating NSD.
Objectives for Cognitive Goal 3:
Learn surgical options for management of NSD, including indications, contraindications, risks and expected outcomes.

1. Gain knowledge of indications (and contraindications) for specific surgical procedures including septal, turbinate, endonasal, endoscopic and external sinus surgeries.
2. Understand expected benefits, potential complications and other risks related to surgical procedures for NSD.

Objectives for Cognitive Goal 4:
Learn perioperative management of patients with NSD.

1. Gain and apply knowledge about disease specific operative risk factors in patients with NSD.
2. Gain and apply knowledge of postoperative care for the NSD patient.

Objectives/Non-Cognitive

Objectives for Non-Cognitive Goal 1:
Obtain Comprehensive understanding and appreciation of the role of practice based learning in Otolaryngology.

Be able to skillfully use scientific evidence and methods to investigate, evaluate and improve patient care practices.

Objectives for Non-Cognitive Goal 2:
Obtain comprehensive understanding and appreciation of the role of professionalism in Otolaryngology.

1. Develop leadership and behavioral skills that reflect commitment to continuous professional development, ethical practice, understanding and sensitivity to diversity, and a responsible attitude toward patients and society.

Objectives for Non-Cognitive Goal 3:
Gain skills of interpersonal communication with patients, peers and staff.

1. Develop and display leadership and interpersonal communications skills that result in and maintain professionalism with patients, families, peers and staff.

Objectives/Technical

Objectives for Technical Goal 1:
Learn skills for proper evaluation of the patient with nasal and sinus disease.

1. Become proficient with detailed history assessment and physical exam
techniques, including endoscopic assessment, of the nasal cavity and sinuses.

**Objectives for Technical Goal 2:**
Learn skills for radiographic evaluation and interpretation of related disorders.

1. Become proficient in knowledge of proper indications, limitations and use of plane films, CT scan, MRI and other related radiographic testing modalities.
2. Become proficient with interpretation and proper application of radiographic imaging.

**Objectives for Technical Goal 3:**
Learn skills for medical management of the nasal/sinus patient.

1. Become familiar with and apply in the clinical setting medical options for the treatment of NSD.
2. Be able to assess response to treatment and adjust treatment as indicated to obtain maximum medical benefit from selected treatment.

**Objectives for Technical Goal 4:**
Learn skills for surgical techniques related to nasal and sinus disorders.

1. Develop basic and advanced surgical techniques and skills for septoplasty, turbinate reduction, polypectomy, and endonasal sinus surgery using a headlight for visualization.
2. Develop basic and advanced surgical techniques and skills for endoscopic sinus surgery including maxillary antrostomy, anterior and posterior ethmoidectomy, sphenoidotomy and nasofrontal recess surgery.
3. Develop skills for performing paranasal sinus surgery using external approaches including Caldwell-Luc, external ethmoidectomy, external nasofrontal sinusotomy, and frontal sinus trephination and obliteration procedures.
4. Develop skills for performing intranasal procedures for related structures including endoscopic dacrocystorhinostomy (DCR), orbital nerve decompression, drainage of subperiosteal orbital abscess, endoscopic resection of localized neoplasms (benign and malignant) and repair of cerebrospinal fluid leaks.

**Objectives for Technical Goal 5:**
Learn skills for perioperative management of the nasal/sinus patient.

1. Be able to appropriately assess patient specific risks factors for NSD surgery.
2. Be able to properly explain planned surgical procedures to patients undergoing NSD surgery.
3. Be able to take appropriate precautions during NSD surgery in order to create a safe surgical environment and prevent intraoperative complications.
4. Be able to recognize and manage intraoperative complications that may occur during surgery for NSD.
5. Understand and apply proper postoperative measures following NSD surgery in order to maximize the best outcome and to prevent postoperative complications.
6. Understand and apply proper postoperative nasal care including in-office endoscopy and debridement techniques.

**FACIAL PLASTIC AND RECONSTRUCTIVE SURGERY – Goals and Objectives**

**Introduction**
The ultimate goal of this rotation is to provide our residents the fundamentals of facial plastic and reconstructive surgery, which will help them to manage conditions that they will face, related to this particular specialty in their practice -either academic or private- after completion of the program. This rotation will improve the residents’ knowledge on the diagnosis and treatment of various conditions in five basic areas of facial plastic and reconstructive surgery: reconstructive surgery, maxillofacial trauma, laser applications, aesthetic surgery of the face, and injectables and fillers.

**Curriculum**

**Reading Assignments:**

*Home Study Course* by the American Academy of Otolaryngology

*Facial Plastic and Reconstructive Surgery* by Papel, Frodel, Holt, Larrabee, Nachlas, Park, Sykes and Toriumi

**Goals**

**Cognitive Goals** *(ACGME Goals: Medical Knowledge, Patient Care, & System-Based Learning)*

1. Increase knowledge in anatomy of the head and neck.
2. Increase knowledge and skill in general evaluation of the patient who presents to the clinic with complaints related to facial plastic and reconstructive surgery.
3. Increase knowledge in basic principles in facial plastic and reconstructive surgery.
4. Increase knowledge and skills in evaluation and management of maxillofacial trauma patient.
5. Learn reconstructive surgical techniques related to the defects in various portions of the face.
6. Increase knowledge in laser applications in the management of various skin conditions.
7. Increase knowledge and skill in evaluation and surgical or non-surgical management of the patients with facial aesthetic concerns.
8. Improve in the ability to write for professional journals.
**Non-Cognitive Goals**

(ACGME Goals: Interpersonal/Communication, Professionalism, Practice-based Learning)

1. Expand professional contact at the regional, national and international level.
2. Develop skills in order to build excellent interpersonal professional relationships with co-residents, facial plastics faculty, residents and the faculty of other departments, nurses, administrative staff and patients in a tertiary care center setting.
3. Be able to gather information from the attending physician regarding expected short or long-term outcomes of patients.

**Technical Goals**

(ACGME Goals: Medical Knowledge, Patient Care, & System-Based Learning)

1. Become proficient in the surgical or non-surgical management of a given condition in facial plastic and reconstructive surgery.

**Objectives/Cognitive**

**Objective for Cognitive Goal 1:**
Increase knowledge in anatomy of the head and neck

1. Be able to describe the anatomy of the skin
2. Be able to describe the anatomy of the craniofacial skeleton and its relations to the underlying and overlying anatomic structures.
3. Be able to describe the vascular anatomy of the head, face and neck.
4. Be able to describe the facial musculature and SMAS
5. Be able to describe the sensory and motor nerve supply to the face
6. Participate in the fresh cadaver dissection course presented at the beginning of the PGY-2 year

**Objective for Cognitive Goal 2:**
Increase knowledge and skill in general evaluation of the patient who presents to the clinic with complaints related to facial plastic and reconstructive surgery.

1. Chief complaint of the patient.
2. History of physical illness or condition
3. Past medical history
4. Past surgical history
5. Past social history
6. Family history
7. Allergies
8. Current medications
9. Systems review
10. Physical exam
   a. HEENT exam
   b. Exam specific to the patient’s chief complaint
11. Photodocumentation
12. Understand patient’s expectations and motive regarding desired surgical or non-surgical procedure(s).

13. Learn the management of the patient with unrealistic expectations and educate the patient regarding what can be or can not be accomplished.

**Objective for Cognitive Goal 3:**
Increase knowledge in basic principles in facial plastic and reconstructive surgery.

1. Increase knowledge in wound healing and wound care.
   a. Learn non-complicated wound care
   b. Learn complicated wound care
   c. Learn how to manage hypertrophic scars and keloids.

2. Increase knowledge and skill in basic soft tissue techniques.
   a. Elliptical excision and linear closure.
   b. M-plasty.
   c. Closure of the wounds with unequal edges by halving technique.
   d. Scar camouflage and revision.
      i. Z-plasty
      ii. Multiple Z-plasties
      iii. Multiple W-plasty
      iv. Geometric broken line closure
   e. Suture techniques
      i. Standard interrupted or running
      ii. Intracuticular
      iii. Vertical or horizontal mattress
      iv. Subcutaneous
   f. Use of staplers
   g. Use of tissue adhesives

3. Learn the difference in between various suture materials and their areas of use.

4. Increase skill in local anesthesia and nerve block techniques in the face.

5. Increase knowledge and skills in performing full thickness and split thickness skin grafts.
   a. Learn how to use a dermatome.
   b. Learn split thickness graft harvesting with scalpel.
   c. Learn how to use a mesher
   d. Learn how to apply a bolster on the skin graft.

**Objective for Cognitive Goal 4:**
Increase knowledge and skills in evaluation and management of maxillofacial trauma patient.

1. Increase knowledge and skill in evaluation of soft tissue injuries of the head and neck.

2. Be able to order appropriate radiological studies and increase knowledge in interpretation of these studies.

3. Learn to differentiate patient who will only need conservative management in a maxillofacial skeletal injury from a patient who will need open or closed reduction with or without fixation.

4. Learn dental occlusal relationships and maxillomandibular fixation (MMF) techniques.
a. Arch bar application
b. Ivy loop application
c. Screw MMF
d. Ernst ligature
e. Rigid and elastic MMF

5. Increase knowledge and skills related to various cranio-maxillo-facial plating systems
   a. Learn the differences between various sizes of plating systems and their applications
   b. Learn to apply an external fixator
   c. Learn compression plating
   d. Learn locking plate application
   e. Learn lag screw fixation

6. Learn various surgical approaches to crani-maxillo-facial skeleton
   a. Hemicoronal or bicoronal approach
   b. Gillies technique
   c. Lateral brow approach
   d. Upper blepharoplasty incision approach
   e. Subciliary approach
   f. Transconjunctival approach
   g. Rhinoplasty approach
   h. Upper gingivolabial/gingivobuccal approach
   i. Lower gingivolabial/gingivobuccal approach
   j. Transbuccal plating
   k. Endoscopic approaches
   l. Transcervical approach

7. Learn surgical treatment of various maxillofacial fractures
   a. Frontal sinus fractures
   b. Naso-orbito-ethmoid fractures
   c. Orbital floor fractures
   d. Tripod fractures
   e. LeFort fractures
   f. Mandibular fractures

8. Learn postoperative management, follow-up and rehabilitation of maxillofacial trauma patient.

9. Increase knowledge on complications and their management in maxillofacial trauma surgery.

**Objective for Cognitive Goal 5:**
Learn reconstructive surgical techniques related to the defects in various portions of the face.

1. Increase knowledge in skin flap physiology and classification
2. Learn facial aesthetic subunit principles and relaxed skin tension lines and their practical values in reconstructive facial surgery
3. Learn cartilage graft harvesting techniques
   a. Auricular cartilage
b. Septal cartilage (in conjunction with septoplasty)
c. Costal cartilage

4. Learn bone graft harvesting techniques
d. Split calvarial bone graft
e. Iliac crest
f. Fibula

5. Learn reconstructive techniques for nasal mucosal lining
g. Septal mucosal flap
h. Bipedicled nasal mucosal flap
i. Composite septal mucocartilaginous flaps
   i. Hett’s technique
   ii. De Quervain’s technique

6. Increase knowledge on use of biologic and synthetic implants in reconstructive surgery
j. Titanium mesh
k. Gold/titanium eyelid implants
l. Porous polyethylene
m. Bone substitutes
n. Silicon/silastic
o. Absorbable polymers (PGA/PLA)
p. Polytetrafluoroethylene
q. Acellular human cadaveric dermis
r. Acellular porcine dermis

7. Increase knowledge on autogenous dermis, fat and fascia harvesting techniques and their applications

8. Increase knowledge of design, utilization and combination of various local flaps in facial reconstruction
s. O-T / A-T / O-H / V-Y and simple advancement flaps
t. Rhombic flap and its variations
u. Bilobed flap and its variations
v. Glabellar flap
w. Nasolabial flap (single-stage or two-stage)
x. Paramedian forehead flap (single-stage or two-stage)
y. Cervicofacial advancement-rotation flap
   i. Mustarde
   ii. Reverse Mustarde

9. Increase knowledge of design and utilization of frequently used regional flaps in head and neck reconstruction
z. Submental island flap
aa. Deltoplectoral flap
bb. Pectoralis major flap with or without skin paddle
c. Trapezius flap

10. Increase knowledge of planning and executing site specific reconstruction in the face
dd. Scalp
e. Nose
ff. Cheek
gg. Lip
hh. Ear
11. Learn postoperative care and management of complications in patients who underwent reconstruction in head and neck
12. Increase knowledge of rehabilitation techniques in facial paralysis
   ii. Primary nerve repair
   jj. Cable nerve grafting
   kk. XII-VII anastomosis
   ll. Masseter transposition
   mm. Temporal muscle transposition
   nn. Static facial slings
   oo. Tarsorraphy
   pp. Implantation of gold weight to the upper eyelid
   qq. Lower lid shortening techniques
13. Learn basic principles in tissue expansion

**Objective for Cognitive Goal 6:**
Increase knowledge of laser applications in the management of various skin conditions.
1. Learn basic principles of laser physics and selective photothermolysis.
3. Learn preoperative considerations, indications, contraindications and postoperative skin care in laser treatments.
4. Learn laser safety precautions.
5. Learn how to operate various laser systems available at our institution and their areas of application.
   a. Erbium YAG laser in skin resurfacing.
   b. Flash lamp pulsed dye laser for vascular lesions and hypertrophic scars.
   c. Q-switch YAG laser and Q-switch Ruby laser for pigmented lesions, tattoos and hair removal.
   d. Continuous wave KTP laser for telangiectasias.
   e. IPL for skin rejuvenation, rosacea and hair removal.
6. Learn other commercially available laser systems and their area(s) of application.
7. Increase knowledge on complications and their management in laser applications.

**Objective for Cognitive Goal 7:**
Increase knowledge and skill in evaluation and surgical or non-surgical management of the patients with facial aesthetic concerns.
1. Learn aesthetic proportions of the face and facial analysis
2. Learn examination and evaluation of an aesthetic patient.
3. Learn how to present physical exam findings to the aesthetic patient.
4. Increase knowledge in basic skin care.
5. Learn patient selection in aesthetic surgery.
6. Increase knowledge on skin rejuvenation techniques.
   a. Botulinum toxin.
   b. Injectable human or bovine collagen.
c. ePTFE.
d. Hyaluronic acid.

7. Increase knowledge on alloplastic facial augmentation materials and their applications.
   a. Cheek augmentation.
   b. Chin augmentation.

8. Increase knowledge on advantages, disadvantages, indications, contraindications, risks, benefits, alternatives, preoperative considerations and postoperative care of various aesthetic surgical procedures.
   a. Browlift
      i. Direct
      ii. Midforehead
      iii. Tricophytic
      iv. Bicoronal
      v. Endoscopic
   b. Upper and lower blepharoplasty with or without orbital fat resection
      i. Skin muscle flap.
      ii. Pinching.
      iii. Transconjunctival.
   c. Facelift/midface lift (I would remove this unless there are plans to start doing these procedures.) I agree (EV). I do not see any light at the end of the tunnel. I recently learned that there will be no financial back-up from the department or from the university in order not to charge the patient for the second time, if a re-do, tuck-up or complication management is necessary. In private practices and well-established academic practices, this is not an issue and the patients undergo this type of procedures for free, when necessary. Since I had a recent need for taking the patient to the OR for a tuck-up and did not have any support from my institution, I refused to be the part of an upcoming advertisement opportunity. I will no longer advertise or push for cosmetic cases. I don’t know if Dr.Moody is willing to proceed with cosmetic advertisement. I would check with him before deleting these (EV)
   d. Septorhinoplasty
      i. Open
      ii. Closed
   e. Increase knowledge on complications and their management in facial aesthetic surgery.

**Objective for Cognitive Goal 8:**

Improve in the ability to write for professional journals.
1. Reporting interesting cases.
2. Write review articles.
3. Publish case series or perform chart reviews for publication.
4. Conduct an original research project.
5. Work as a co-author in a publication project carried out by staff.
Objective/Non-Cognitive

**Objective for Non-Cognitive Goal 1:**
Expand professional contact at the regional, national and international level.
1. Attend regional, national or international meetings.
2. Present papers in these meetings.
3. Publish papers (Cognitive goal # 8)

**Objective for Non-Cognitive Goal 2:**
Develop skills in order to build excellent interpersonal professional relationships with co-residents, facial plastics faculty, residents and faculty of other departments, nurses, administrative staff and patients in a tertiary care center setting.
1. Be able to demonstrate good behavior even under stressful conditions.
2. Learn to be an effective listener.
3. Be able to perform resident duties in a timely and orderly fashion.

**Objective for Non-Cognitive Goal 3:**
Be able to gather information from the attending physician regarding expected long-term outcomes of particular surgeries.
1. Communicate with the attending physicians.

Objective/Technical

**Objective for Technical Goal 1:**
Become proficient in the surgical or non-surgical management of a given condition in facial plastic and reconstructive surgery.
1. Follow professional journals on facial plastic and reconstructive surgery
2. Take instructional courses in AAOHNSF and/or AAFPRS meetings
3. Read specific textbooks and atlases
4. Watch videos or DVDs recorded by other surgeons
5. Attend basic science and didactic lectures, as well as monthly journal club meeting on plastic and reconstructive surgical topics.
Sleep Disordered Breathing – Goals and Objectives

Introduction
The resident is expected to obtain sufficient knowledge to diagnose and medically and surgically treat the spectrum of disorders known as “Sleep Disordered Breathing” (SDB) (i.e. simple and habitual snoring, Upper Airway Resistance Syndrome, Sleep Hyppopnea/ Sleep Apnea, and Pickwickian Syndrome).

The resident is expected to gain this knowledge by reading appropriate textbooks and journals, attending related lectures, participating in relevant Grand Rounds and Journal Clubs, observing and performing supervised patient evaluations and, as appropriate for level of training, assist with and perform surgical procedures for the treatment of the SDB.

It is expected that as the resident obtains knowledge and experience of SDB diagnosis and management that he/she will be given, graduated responsibility for care of the SDB patient and as appropriate will assist with teaching and supervision of lower level residents.

Curriculum Specific Reading Materials:

Goals

Cognitive Goals:
(ACGME Competencies: Medical Knowledge, Patient Care & System Based Learning)
1. Expand understanding of the evaluation of patients with suspected or previously diagnosed SDB.
2. Expand knowledge of non-surgical options for management of patients with SDB.
3. Learn surgical options for management of SDB, including indications, contraindications, risks and expected outcomes of specific procedures.
4. Learn perioperative management protocols for patients with SDB.

Non-Cognitive Goals:
(ACGME Competencies: Interpersonal/Communication, Professionalism, Practice-based learning)
1. Obtain comprehensive understanding and appreciation of the role of practice based learning in Otolaryngology.
2. Obtain comprehensive understanding and appreciation of the role of professionalism in Otolaryngology.
3. Gain skills of interpersonal communication with patients, peers and staff.

Technical Goals:
(ACGME Competencies: Medical Knowledge, Patient Care)
1. Develop training level appropriate skills with surgical techniques for SDB.
2. Learn skills for interpreting surgically relevant Polysomnography (PSG) results.
Objectives/Cognitive

Objectives for Cognitive Goal 1:
Expand understanding of the evaluation of patients with suspected or previously diagnosed SDB.

1. Be able to recognize the symptoms and physical signs in the SBD patient.
2. Be able to discuss the different aspects or stages of SBD from simple snoring to Pickwickian syndrome.
3. Be able to analyze physical findings and their implications in the SBD patient.
4. Be able to apply physical findings and diagnostic studies in the SBD patient in order to make appropriate medical or surgical treatment recommendations.

Objectives for Cognitive Goal 2:
Expand knowledge of non-surgical options for management of patients with SDB.

1. Understand medical management options and their indications for treatment of SDB including physical measures such as weight loss, sleep positioning and supplemental oxygen.
2. Understand other non-surgical options and their indications for managing SDB including CPAP (including Bi-Pap and Autopap) and oral appliances.

Objectives for Cognitive Goal 3:
Learn surgical options and their application for management of SDB, including indications, contraindications, risks and potential benefits of specific procedures.

1. Gain knowledge of indications for tracheotomy, nasal and sinus surgery, maxillofacial/oral surgery, oropharyngeal surgery and tongue surgery as they relate to surgical management of SDB.
2. Learn specific indications for and limitations of selected “in-office” procedures such as LAUP, Radiofrequency Ablation and Palatal Implants, for managing snoring, UARS and sleep apnea.
3. Understand the need for and indications of “combination” procedures (i.e. nasal and oropharyngeal surgery, tongue and tongue base procedures and maxillofacial surgery) for treating multilevel obstruction in SDB.
4. Be able to explain expected benefits, potential complications and other risks related to surgical procedures for SDB.

Objectives for Cognitive Goal 4:
Learn perioperative management protocols for patients with SDB.

1. Gain and apply knowledge about disease specific operative risk factors in patients with SBD.
2. Gain and apply knowledge of postoperative care for the SDB patient including post-anesthetic complications of hypoventilation and cardiac dysrhythmia, and the potential safety benefits of post-operative monitoring.
3. Gain experience with adequate pain management and its limitations in postoperative care of SDB patients.
4. Gain and apply knowledge of the indications for and timing of post-surgical polysomnography studies.

**Objectives/Non-Cognitive**

**Objectives for Non-Cognitive Goal 1:**
Obtain comprehensive understanding and appreciation of the role of practice based learning in Otolaryngology.

1. Be able to skillfully use scientific evidence and methods to investigate, evaluate and improve patient care practices.
2. Remain knowledgeable of current trends in medical and surgical management of SDB.

**Objectives for Non-Cognitive Goal 2:**
Obtain comprehensive understanding and appreciation of the role of professionalism in Otolaryngology.

1. Develop leadership and behavioral skills that reflect commitment to continuous professional development, ethical practice, understanding and sensitivity to diversity and responsible attitude toward patients and society.

**Objectives for Non-Cognitive Goal 3:**
Gain skills of interpersonal communication with patients, peers and staff.

1. Develop and display leadership and interpersonal communications skills that result in and maintain professionalism with patients, families, peers and staff.
2. Learn and apply communication skills by interacting with providers in related specialties, i.e. Sleep Specialists, Oral-Maxillofacial Surgeons, Dentists, Pulmonologists and others who treat SDB.

**Objectives/Technical**

**Objectives for Technical Goal 1:**
Develop training level appropriate skills with surgical techniques for SDB.

1. Develop basic and advanced surgical techniques and skills with tracheotomy (temporary and permanent), nasal surgery (including septoplasty and turbinate reduction), tonsillectomy, uvulopalatopharyngoplasty, and selected tongue procedures (i.e. reduction, genioglossus advancement and hyoid suspension).
2. Develop surgical techniques and skills for certain “in-office” procedures such as Laser Assisted Uvulopalatoplasty, Radiofrequency Ablation and Palatal Implants.
Objectives for Technical Goal 2:
Learn Skills for interpreting surgically relevant Polysomnography (PSG) results.

1. Recognize and apply PSG results including sleep stage analysis, oxy-hemoglobin saturation measurements, hypopneas, apneas, and RDI/AHI.
2. Recognize and apply PSG results related to application of Continuous Positive Airway Pressure (CPCP) trials.

Laryngology, “Voice And Swallowing”
Goals and Objectives

Cognitive Goals

1. Learn the basic anatomy / physiology of voice production

   **Cognitive Objectives:**
   1. Discuss the 3 aspects of voice production, lung (*generator*), larynx (*vibrator*), vocal tract (*resonator*) and how they interact.
   2. Explain how pathology in these 3 areas lead to dysphonia.

2. Learn the basic anatomy / physiology of swallowing.

   **Cognitive Objectives:**
   1. Discuss the 3 phases of swallowing.
   2. Discuss what the components of a normal modified barium swallow.

3. Become familiar with various categories of dysphonia and their etiologies.

   **Cognitive Objectives:**
   1. Discuss the various etiologies and their evaluation and management.
      a. Vocal cord paralysis (unilateral / bilateral) and fixation.
      b. Laryngeal papillomas.
      c. Benign vocal cord lesions (nodules, polyps, cysts).
      d. Systemic inflammatory diseases of the larynx.
      e. Laryngeal leukoplakia / dysplasia
      f. Laryngopharyngeal reflux.
      g. Vocal cord scar.

4. Learn how to perform a history and physical in the patient with dysphonia and dysphagia.

   **Cognitive Objectives:**
   1. Describe the pertinent history in a patient with dysphonia.
   2. Describe the pertinent history in a patient with dysphagia.
3. Understand Pathophysiology of gastroesophageal and laryngopharyngeal reflux.
4. Ability to perform flexible and rigid indirect laryngoscopy with stroboscopy.
5. Increase skill with stroboscopy interpretation.
7. Discuss other tests used in the evaluation of dysphagia.
   a. Modified barium swallow
   b. Barium swallow
   c. Esophageal manometry
   d. FEES / FEESST

5. Learn basic concepts of laryngeal phonosurgery

**Cognitive Objectives:**
1. Be able to discuss the concept behind mucosal-sparing procedures of the larynx.
   (vocal cord microflaps)
2. Be able to discuss the rational behind vocal cord medialization procedures and the advantages / disadvantages of the various procedures.

6. Increase knowledge about adult and pediatric stridor.

**Cognitive Objectives:**
1. Be able to formulate a through differential dx for adult stridor.
2. Be able to discuss the evaluation / management of subglottic-tracheal stenosis.

**Technical Goals**

1. Increase skill with direct laryngoscopy and laryngeal microsurgery, including use of lasers. Evaluate for limitations for microlaryngoscopy.

**Technical Goals:**
1. Perform direct laryngoscopy with the use of microflap techniques for removal of benign lesions.
2. Efficiently use the CO₂ laser in laryngeal procedures.

2. Increase skill in managing the difficult adult airway.

**Technical Goals:**
1. Perform subglottoscopy with endoscopic laser incision / dilation of subglottic / tracheal stenosis.
2. Perform tracheotomy.
3. Perform cricotracheal / tracheal resection.

3. Increase skill with flexible and rigid esophagoscopy.

**Technical Goals:**
- 1. Perform rigid esophagoscopy with biopsy / dilation in OR.

4. Increase skill with surgical management of patients with dysphagia.

**Technical Goals:**
- 1. Perform cricopharyngeal myotomy.
- 2. Perform zenker’s diverticulotomy / diverticulectomy.

5. Increase skill in surgical management of patients with vocal cord paralysis.

**Technical Goals:**
- 1. Perform vocal cord injections (various approaches).
- 2. Perform thyroplasty.

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**OTOLOGY – Goals and Objectives**

**Introduction**

The fundamental focus for this resident rotation is expanded clinical experience and depth in diagnosis and treatment of otologic and neurotologic conditions. Principles of diagnosis and treatment are taught progressively and continuity of care is emphasized. This rotation gives residents in-depth experience with the diagnosis and management of middle ear pathology.

The otolaryngology resident will be supervised and instructed by fellowship trained staff otologists / neurotologists. When more senior residents are present on the service a hierarchical system will prevail, with the junior resident reporting to the senior resident or chief resident of the surgical team, who in turn reports to the attending staff. It is expected that, until delegated more authority, the junior resident will discuss all issues with the chief resident or attending staff. Senior residents and attending surgical staff will be available in a rapid reliable manner. Delegation of authority and responsibility for patient care will increase as the resident demonstrates increased competence in the delivery of safe, effective, and compassionate care. The otolaryngology staff will formally evaluate each otolaryngology trainee’s performance at the end of the rotation.
The organization, including the Program Requirements and Duties of the Otology teaching service(s) and clinic(s) are as follows:

The Otology resident has primary responsibility for Otology cases through Dr. Dornhoffer. Otology cases may be deferred to other residents at ACH or UAMSMC if desired. The mid level resident at ACH will act as the “ACH chief resident” and have priority over non otology cases at ACH. Cases may be shared with the Otology resident. The ACH chief resident will have primary responsibility for managing ACH clinic, OR, consults and rounds.

The Otology resident must communicate with the mid level resident and/or ACH staff when finished with Otology duties each day. Assisting with consults, rounds, teaching or O.R. duties may be required of the Otology chief resident. If confusion persists or abuse of the above is suspected, this should be discussed with Dr.’s Bower, Dornhoffer, Welch and Richter.

Otology Residents will not be required to perform morning rounds at ACH. While rarely required, occasional weekend rounds may be covered by the Otology resident.

The Otology Resident is required to attend the monthly Neurotology Conference overseen by Dr. John Dornhoffer at 8:15 a.m. on the 2nd Tuesday of each month. Afternoon teaching rounds at ACH may be required on the days that Dr. Dornhoffer is present at ACH. This will be at the discretion of Dr.’s Bower and Dornhoffer.

The Otology Resident should gain clinical, surgical and case management knowledge in several areas during this rotation: hearing and vestibular disorders, middle ear surgery, skull base procedures, hearing rehabilitation, vestibular rehabilitation, cochlear implants and implantable hearing aids.

Curriculum

Reading Assignments:
Home Study Course by the American Academy of Otolaryngology
The Ear, Comprehensive Otology by Canalis and Lambert.
Products
1. Required submission of tests from the Home Study Course
2. One oral presentation given at the interdisciplinary Neurotology Conference

Goals

Cognitive Goals – Otology Rotation
(ACGME Competency: Medical Knowledge, Patient Care, & System-Based Practice)
1. Increase skill in performing the otologic examination.
2. Increase skill in performing the general and targeted otologic/neurotologic history and review.
3. Increase skill in presenting new and established otology patients in a concise and focused manner.
4. Increase skill in the diagnosis and management of patients who present to the otology/neurotology clinic.
5. Increase knowledge about indication, contraindications, and risks of otologic/neurotologic surgical procedures; also learn the alternatives to such procedures.
6. Learn the perioperative management of surgical patients who present to the otology/neurotology clinic.
7. Expand knowledge of otologic/neurotologic diagnostic radiology.
8. Expand knowledge of otologic anatomy and embryology.
9. Acquire core knowledge in otology/neurotology through book reviews and departmental educational activities.
10. Improve in the ability to write for professional journals.

**Non-Cognitive Goals – Otology Rotation**

*ACGME Competency: Interpersonal/Communication, Professionalism, System-Based Practice*

1. Expand contact in the regional professional environment.
2. Develop an understanding of professional practice in a specialty hospital environment, including an appreciation of the different styles of interacting with otologic/neurotologic patients and their families.
3. Continue the habit of intermediate and long-term planning.

**Technical Goals – Otology Rotation**

*ACGME Competency: Medical Knowledge, Patient Care, & System-Based Practice*

1. Gain additional experience in otologic and neurotologic procedures.
2. Gain experience in temporal bone drilling.

**Objectives/Cognitive**

**Objective for Cognitive Goal 1:**

Increase skill in performing the otologic examination through supervised patient encounters in the outpatient clinics.

1. Increase skill in using the pneumatic otoscope, otologic microscope.
2. Increase knowledge of abnormal anatomy
3. Be able to describe the elements of a complete otologic/neurotologic specialty outpatient clinical note.
4. Be able to describe the common and uncommon anomalies and conditions that may be encountered in the otologic/neurotologic exam.

**Objective for Cognitive Goal 2:**

Increase skill in performing the general and targeted otologic/neurotologic history and review.

1. Be able to describe the elements of a complete and targeted otologic/neurotologic history including the patient’s
   a. Chief complaint
   b. Current illness history
c. Allergies
d. Medications
e. Previous surgeries
f. Pertinent social history and cultural background

2. Be able to review systems, emphasizing systemic conditions that may affect the ear and balance.

3. Be able to efficiently conduct a complete and targeted head and neck history and systems review including the elements that are described above in Objective 1.

Objective for Cognitive Goal 3:
Increase skill in presenting new and established otology patients in a concise and focused manner.

1. Be able to consistently present the patient’s history and the pertinent physical findings, putative diagnosis, and proposed management plan to staff in a concise and organized way.

2. Objective for Cognitive Goal 4:
Increase skill in the diagnosis and management of patients who present to the otology / neurotology clinic.

1. Be able to interpret and auditory brainstem evoked response test (ABR).
2. Be able to interpret an audiogram.
3. Be able to describe the natural history, clinical presentation, and evaluation of otitis media and any treatment options.
4. Be able to describe the potential complications of acute otitis media and management options for each complication.
5. Know the appropriate medication for acute and chronic otitis media and be able to explain bacteriology and the patterns of resistance that influence selection of antibiotics.
6. Be able to describe the diagnostic criteria of central auditory disorders.
7. Be able to describe the appropriate audiologic interventions (hearing aids, Bone Anchored Hearing Aid (BAHA), cochlear implant) based on the patient’s audiologic situation.
8. Be able to efficiently evaluate patients with dizzy/vertigo complaints such as:
   a. Benign Paroxysmal Positional Vertigo (BPPV)
   b. Meniere’s disease
   c. Vestibular neuritis
   d. Superior canal dehiscence
   e. Perilymphatic fistula
   f. Multisensory disorder
   g. Postural hypotension / vascular
   h. CNS causes
9. Be able to describe the appropriate management of the aforementioned diagnoses.
10. Be able to describe the evaluation and management of the atelectatic ear.
11. Be able to describe the evaluation and management of cholesteatoma
12. Be able to describe the types, natural history, and managements of different neurotologic neoplasms.
13. Be able to describe the evaluation and management of different facial nerve disorders
14. Be able to describe the Arnold-chiari malformation and its neurotologic manifestations.

Objective for Cognitive Goal 5:
Increase knowledge about indication, contraindications, and risks of otologic / neurotologic surgical procedures; also learn the alternatives to such procedures.

1. Be able to describe the surgical options for the treatment of otitis media, including the indications and risks of such options and alternative to surgery.
2. Be able to describe the surgical options for the treatment of complicated otitis media and alternatives.
3. Be able to describe the surgical options for treating temporal bone paragangliomas and alternatives.
4. Be able to describe the surgical options for treating vestibular schwannomas and alternatives.
5. Be able to describe the surgical options for treating cholesteatomas and alternatives.
6. Be able to describe the surgical options for treating tympanic membrane perforations and alternatives.
7. Be able to describe the surgical options for treating vertigo and alternatives.

Objective for Cognitive Goal 6:
Learn the perioperative management of surgical patients who present to the otology / neurotology clinic.

1. Be able to outline the expected perioperative course for common otologic/neurotologic procedures and the indicators of potential complications that arise in the perioperative period including:
   a. Myringotomy and tympanostomy tube placement
   b. Tympanoplasty
   c. Mastoidectomy
   d. Labyrinthectomy
   e. Endolymphatic sac surgery
   f. Translabyrinthine craniotomy
   g. Retrosigmoid craniotomy
   h. Middle fossa craniotomy
   i. Cochlear implantation
   j. Canaloplasty
   k. Meatoplasty
   l. Intratympanic gentamicin
Objective for Cognitive Goal 7:
Expand knowledge of otologic/neurotologic diagnostic radiology.

1. Be able to identify important features and landmarks of otologic and neurotologic studies:
2. Axial/coronal CT scan
3. T1/T2 MRI
4. Be able to identify classic appearance of common and uncommon otologic diagnosis.

Objective for Cognitive Goal 8:
Expand knowledge of otologic anatomy and embryology.

1. Be able to describe the surgical anatomy of the temporal bone
2. Be able to describe the embryology of the temporal bone
3. Be able to describe the surgical anatomy of the facial nerve
4. Be able to describe the embryology of the facial nerve

Objective for Cognitive Goal 9:
Acquire core knowledge in otology/neurotology through book reviews and departmental educational activities.

1. Be able to produce one study question from each chapter of *The Ear, Comprehensive Otology* by Canalis and Lambert in word .doc format and submit to program secretary.

Objective for Cognitive Goal 10:
1. Improve in the ability to write for professional journals.
2. Write a paper (or a case report on an interesting case that has been encountered during the rotation) and submit it for publication.

Objective/Non-Cognitive

Objective for Non-Cognitive Goal 1:
Expand contact in the regional professional environment.

1. Be able to show evidence of implementation of a networking system.
2. Have and be able to demonstrate a system (card, computer, or other) for recording information about professional contacts.

Objective for Non-Cognitive Goal 2:
Develop an understanding of professional practice in a specialty hospital environment, including an appreciation of the different styles of interacting with otologic/neurotologic patients and their families.

1. Be able to demonstrate an appropriate approach to the evaluation of pediatric patients in the specialty clinic environment.
Objective for Non-Cognitive Goal 3:
Continue the habit of intermediate and long-term planning.

1. Have written one-year and five-year goals.

Objective/Technical

Objective for Technical Goal 1:
Gain additional experience in otologic and neurotologic procedures.

1. Be able to efficiently perform tympanoplasty tube placement.
2. Be able to efficiently perform a simple tympanoplasty
3. Be able to efficiently perform a complete mastoidectomy

Objective for Technical Goal 2:
Gain experience in temporal bone drilling.

1. Develop surgical drilling skills through supervised cadaveric temporal bone drilling in temporal bone laboratory on a regularly scheduled basis.
2. Develop clinical and surgical skills to allow safe and effective surgical treatment of otologic diseases under the supervision of the attending otologist/neurotologist.

GERIATRIC – Goals and Objectives

Introduction
This program is to enhance the resident’s knowledge and skills in taking care of otolaryngologic problems in the geriatric population. It is known that the geriatric population will continue to grow in the next several years. To meet this demand, more emphasis is being directed toward educating doctors in geriatric medical issues that this specialty will face. The resident will learn how to work with other geriatric trained specialists in order to provide the best medical care for this aging population.

Curriculum
Specific Reading Assignments
Geriatric Otolaryngology, Calhoun and Eibling
Geriatrics – At Your Fingertips (booklet from the American Geriatric Society)
GSR (geriatric specialty residents program) teaching modules developed with assistance from the American Geriatric Society

Goals (Cognitive Goals) ACGME goals: Medical Knowledge, Patient Care, & System Based learning
1. The resident will expand their understanding and knowledge about age related disease processes in the field of otolaryngology.
2. Learn medical treatments (both non-surgical and surgical) for otolaryngologic diseases of the geriatric population.
3. The resident will learn how the diseases affect the older population.
4. The resident will learn through supervision in clinic, hospital and operating room how to apply this knowledge and develop the best treatment plan for each geriatric patient.

5. The resident will learn to work with and assist other geriatric trained specialists in caring for this group.

**Non cognitive Goals**

1. Learn skills for evaluating, diagnosing and arranging individualized treatment plan for the geriatric patients.

2. Learn how other diseases may affect the outcome of these treatment plans and be able to modify them to each patient.

3. Learn and understand how the patient’s medications can affect treatment plan and outcome.

4. Learn communication skills to be able to discuss findings with the patient, care giver and/or family.

5. Learn to explain goals and outcomes of medical and surgical treatment options with the patient, care giver and/or family.

**Objectives**

The resident will learn to know how to assess the geriatric patient, determine the diagnosis, and develop a treatment plan. 

The resident will be able to provide medical information that will be valuable in treating the geriatric patient.

The resident will be able to explain the findings and treatment plan that is most suited for the patient’s medical problem to the geriatric patient, family and caregiver.
Hospital / Rotation
Competency Based
Goals and Objectives for
the Program

UAMS MC: University Hospital
ACH: Arkansas Children's Hospital
CAVHS: Veterans Hospital
UAMS MC - University of Arkansas for Medical Science Hospital Rotation:

Goals and Objectives

Introduction

The fundamental focus of the University resident rotation is expanded clinical experience and depth in diagnosis and treatment of adult otolaryngology conditions. The UAMS MC chief resident is expected to have in-depth knowledge of the diagnosis and treatment of all otolaryngologic conditions. This rotation provides residents with an in-depth experience in the diagnosis and management of sinonasal disease, neuro-otologic disorders, head and neck neoplasms, facial plastic and reconstructive, allergy, sleep disordered breathing, and voice and swallow disorders as well as other areas of general otolaryngology. The chief resident on the UAMS MC rotation is expected to further refine their knowledge base by actively reading and participating in the education of junior residents.

The organization, including the Program Requirements and Duties of the UAMS MC teaching service(s) and clinic(s) are as follows:

Residents on the UAMS MC otolaryngology rotation gain clinical, surgical, and case management knowledge for adult patients in several areas including head and neck oncology, skull base surgery, thyroid / parathyroid, sinus disease, allergy, trauma, facial plastic and reconstructive surgery, otology/neurotology, laser surgery, voice, general ENT, and endoscopy. Four residents rotate at UAMS MC each month. The chief resident spends the majority of time in the OR, with mid to lower level residents rotating on a weekly basis between the OR and clinical coverage. Otolaryngology residents are responsible for 50% of the patients in clinics, 90% of patients in the OR and 100% of hospital, ER and in-patient care. Residents are 100% under the direction of a staff physician at all times regarding patient care.

Curriculum

Reading Assignments:
Home Study Course by the American Academy of Otolaryngology
Select peer review articles from Otolaryngology journals - monthly

Supplemental Reading:

**Otology**
The Ear, Comprehensive Otology by Canalis and Lambert.

**Allergy**
Allergy in ENT Practice: The Basic Guide, King, et al, 2005
Food Allergy, Trevino, et al, 1997
Sinus

Plastic / Reconstructive
*Facial Plastic and Reconstructive Surgery* by Papel, Frodel, Holt, Larrabee, Nachlas, Park, Sykes and Toriumi

Head and Neck
*Cancer of the Head & Neck* by Meyers and Suen
*Atlas of Head and Neck Surgery* by Lore and Medina
*Head and Neck Pathology with Clinical Correlation* by Wenig

Sleep Disorders
Voice and Swallowing

Products
1. Required submission of tests from the *Home Study Course*

Conferences
1. Multidisciplinary Head and Neck Tumor Conference - Weekly
2. Morbidity and Mortality Conference – 2 – 3 times per month
3. Interesting case conference - monthly
4. Departmental Grand Rounds - monthly
5. Neurotology Conference (otology resident)

Goals

**Cognitive Goals** - University of Arkansas for Medical Science UAMS MC Hospital Rotation
*(ACGME Goals: Medical Knowledge, Patient Care, & System-Based Learning)*

**Otology / Neurotology**
1. Increase skill in performing the otologic examination.
2. Increase skill in performing the general and targeted otologic/neurotologic history and review.
3. Increase skill in presenting new and established otology patients in a concise and focused manner.
4. Increase skill in the diagnosis and management of patients who present to the otology / neurotology clinic.
5. Increase knowledge about indication, contraindications, and risks of otologic / neurotologic surgical procedures; also learn the alternatives to such procedures.
6. Learn the perioperative management of surgical patients who present to the otology / neurotology clinic.
7. Expand knowledge of otologic \ neurotologic diagnostic radiology.
8. Expand knowledge of otologic anatomy and embryology.
9. Acquire core knowledge in otology \ neurotology through book reviews and departmental educational activities.
10. Improve in the ability to write for professional journals.
11. Present at Neurotology case conference.

**Allergy / Rhinology**
1. Learn the history and evolution of Otolaryngic Allergy.
2. Learn basic immunology related to allergic etiology and symptomatology.
3. Learn concepts, specific etiologies and symptomatology of seasonal and perennial allergies.
4. Learn theory and principles of food related allergy, etiology and diagnosis.
5. Expand knowledge about medications useful for the treatment of allergy, their indications, contraindications, appropriate dosing and side effects.
6. Learn principles, techniques and indications for testing the suspected allergic patient.
7. Learn clinical indications for and techniques for immunotherapy.
8. Learn the signs, symptoms and treatment anaphylaxis.

**Plastic / Reconstructive**
1. Increase knowledge in anatomy of the head and neck.
2. Increase knowledge and skill in general evaluation of the patient who presents to the clinic with complaints related to facial plastic and reconstructive surgery.
3. Increase knowledge in basic principles in facial plastic and reconstructive surgery.
4. Increase knowledge and skills in evaluation and management of maxillofacial trauma patient.
5. Learn reconstructive surgical techniques related to the defects in various portions of the face.
6. Increase knowledge in laser applications in the management of various skin conditions and vascular lesions.
7. Increase knowledge and skill in evaluation and surgical or non-surgical management of the patients with facial aesthetic concerns.
8. Improve in the ability to write for professional journals.

**Head and Neck**
1. Increase skill in performing the general and targeted head and neck history and review of systems.
2. Develop an intermediate to advanced level of knowledge of the analysis of preoperative risk factors that influence perioperative and intraoperative management of oncology patients.
3. Increase skill in performing the head and neck examination.
4. Increase skill in presenting new and established oncology patients in a concise and focused manner.
5. Develop an intermediate to advanced level of knowledge of the surgical anatomy and physiology of head and neck neoplasia.
6. Increase knowledge of speech, digestive, and physical rehabilitative options for oncology patients.
7. Develop an intermediate to advanced knowledge of the surgical, radiological, immunological, and chemotherapeutic options that are available for the treatment of head and neck neoplasia.
8. Learn about benign and malignant thyroid disorders
9. Learn about parathyroid disease.
10. Learn about PET imaging of malignancies.

**Sleep Disorders**

1. Expand understanding of the evaluation and management of patients with SDB.
2. Expand knowledge about medical and non-surgical options for management of patients with SDB.
6. Learn surgical options for management of SDB, including indications, contraindications, risks and expected outcomes.
7. Learn perioperative management of patients with SDB.

**Non-Cognitive Goals - University of Arkansas for Medical Science UAMS MC Hospital Rotation**

(ACGME Goals: Interpersonal/Communication, Professionalism, Practice-based Learning)

1. Expand contact in the regional professional environment.
2. Develop an understanding of professional practice in a specialty hospital environment, including an appreciation of the different styles of interacting with otologic \ neurotologic patients and their families.
3. Continue the habit of intermediate and long-term planning.

**Head and Neck**

1. Develop an understanding of the significant psychosocial, economic and physical stresses and their manifestations that life-threatening conditions have on patients and their families.
2. Develop an understanding of professional practice in a specialty hospital environment, including an appreciation of the different styles of interacting with head and neck cancer patients and their families.
3. Develop skills in managing the psychosocial aspects of head and neck oncology patient care.

**Technical Goals - University of Arkansas for Medical Science UAMS MC Rotation**

*(ACGME Goals: Medical Knowledge, Patient Care, & System-Based Learning)*

**Otology / Neurotology**

1. Gain additional experience in otologic and neurotologic procedures.
2. Gain experience in temporal bone drilling.

**Allergy / Rhinology**

1. Learn to interpret symptoms and physical signs of inhalant allergy.
2. Learn techniques for inhalant allergy testing.
3. Learn application of avoidance and medical management for inhalant allergy.
4. Learn methods for diagnosis and treatment of fixed and cyclic food allergy.
5. Learn techniques necessary for providing immunotherapy.

**Plastic / Reconstructive**

1. Learn alternative or different techniques in the surgical or non-surgical management of a given condition in facial plastic and reconstructive surgery.
2. Understand open reduction and internal fixation of fractures.

**Head and Neck**

1. Gain additional experience in a wide range of head and neck oncological procedures.
2. Obtain an intermediate level of skill in head and neck oncological procedures.
3. Exposure to ambulatory ultrasonography of thyroid/neck

**Sleep Disorders**

1. Learn skills with surgical techniques for SDB.
2. Learn Skills understanding Polysomnogram results.

**Objectives**

**Cognitive Objectives – University of Arkansas for Medical Science UAMS MC Hospital Rotation**

**Otology / Neurotology**

**Objective for Cognitive Goal 1:**
Increase skill in performing the otologic examination through supervised patient encounters in the outpatient clinics.
1. Increase skill in using the pneumatic otoscope, otologic microscope.
2. Increase knowledge of abnormal anatomy
3. Be able to describe the elements of a complete otologic / neurotologic specialty outpatient clinical note.
4. Be able to describe the common and uncommon anomalies and conditions that may be encountered in the otologic / neurotologic exam.

Objective for Cognitive Goal 2:
Increase skill in performing the general and targeted otologic/neurotologic history and review.

1. Be able to describe the elements of a complete and targeted otologic / neurotologic history including the patient’s
   a. Chief complaint
   b. Current illness history
   c. Allergies
   d. Medications
   e. Previous surgeries
   f. Pertinent social history and cultural background
2. Be able to review systems, emphasizing systemic conditions that may affect the ear and balance.
3. Be able to efficiently conduct a complete and targeted head and neck history and systems review including the elements that are described above in Objective 1.

Objective for Cognitive Goal 3:
Increase skill in presenting new and established otology patients in a concise and focused manner.

1. Be able to consistently present the patient’s history and the pertinent physical findings, putative diagnosis, and proposed management plan to staff in a concise and organized way.

Objective for Cognitive Goal 4:
Increase skill in the diagnosis and management of patients who present to the otology / neurotology clinic.

1. Be able to interpret and auditory brainstem evoked response test (ABR).
2. Be able to interpret an audiogram.
3. Be able to describe the natural history, clinical presentation, and evaluation of otitis media and any treatment options.
4. Be able to describe the potential complications of acute otitis media and management options for each complication.
5. Know the appropriate medication for acute and chronic otitis media and be able to explain bacteriology and the patterns of resistance that influence selection of antibiotics.

6. Be able to describe the diagnostic criteria of central auditory disorders.

7. Be able to describe the appropriate audiologic interventions (hearing aids, Bone Anchored Hearing Aid (BAHA), cochlear implant) based on the patient’s audiologic situation.

8. Be able to efficiently evaluate patients with dizzy/vertigo complaints such as:
   a. Benign Paroxysmal Positional Vertigo (BPPV)
   b. Meniere’s disease
   c. Vestibular neuritis
   d. Superior canal dehiscence
   e. Perilymphatic fistula
   f. Multisensory disorder
   g. Postural hypotension / vascular
   h. CNS causes

9. Be able to describe the appropriate management of the aforementioned diagnoses.

10. Be able to describe the evaluation and management of the atelectatic ear.

11. Be able to describe the evaluation and management of cholesteatoma

12. Be able to describe the types, natural history, and managements of different neurotologic neoplasms.

13. Be able to describe the evaluation and management of different facial nerve disorders

14. Be able to describe the Arnold-chiari malformation and its neurotologic manifestations.

**Objective for Cognitive Goal 5:**
Increase knowledge about indication, contraindications, and risks of otologic / neurotologic surgical procedures; also learn the alternatives to such procedures.

1. Be able to describe the surgical options for the treatment of otitis media, including the indications and risks of such options and alternative to surgery.

2. Be able to describe the surgical options for the treatment of complicated otitis media and alternatives.

3. Be able to describe the surgical options for treating temporal bone paragangliomas and alternatives.

4. Be able to describe the surgical options for treating vestibular schwannomas and alternatives.

5. Be able to describe the surgical options for treating cholesteatomas and alternatives.

6. Be able to describe the surgical options for treating tympanic membrane perforations and alternatives.
7. Be able to describe the surgical options for treating vertigo and alternatives.

Objective for Cognitive Goal 6:
Learn the perioperative management of surgical patients who present to the otology / neurotology clinic.

1. Be able to outline the expected perioperative course for common otologic/neurotologic procedures and the indicators of potential complications that arise in the perioperative period including:
   a. Myringotomy and tympanostomy tube placement
   b. Tympanoplasty
   c. Mastoidectomy
   d. Labyrinthectomy
   e. Endolymphatic sac surgery
   f. Translabyrinthine craniotomy
   g. Retrosigmoid craniotomy
   h. Middle fossa craniotomy
   i. Cochlear implantation
   j. Canaloplasty
   k. Meatoplasty
   l. Intratympanic gentamicin

Objective for Cognitive Goal 7:
Expand knowledge of otologic / neurotologic diagnostic radiology.

1. Be able to identify important features and landmarks of otologic and neurotologic studies:
   a. Axial/coronal CT scan
   b. T1/T2 MRI
2. Be able to identify classic appearance of common and uncommon otologic diagnosis.

Objective for Cognitive Goal 8:
Expand knowledge of otologic anatomy and embryology.

1. Be able to describe the surgical anatomy of the temporal bone
2. Be able to describe the embryology of the temporal bone
3. Be able to describe the surgical anatomy of the facial nerve
4. Be able to describe the embryology of the facial nerve

Objective for Cognitive Goal 9:
Acquire core knowledge in otology / neurotology through book reviews and departmental educational activities.
1. Be able to produce one study question from each chapter of *The Ear, Comprehensive Otology* by Canalis and Lambert in word .doc format and submit to program secretary.

**Objective for Cognitive Goal 10:**
Improve in the ability to write for professional journals.

1. Write a paper (or a case report on an interesting case that has been encountered during the rotation) and submit it for publication.

### Allergy / Rhinology

**Objectives for Cognitive Goal 1:**
Learn the history and evolution of Otolaryngic Allergy.

1. Develop an understanding of how otolaryngic allergy testing and treatment methods evolved in relation to experiential clinical knowledge and evidence-based research.
2. Understand the methods of testing and treatment of allergies by the otolaryngology community and how they compare and differ from the methods of the General Allergy community.

**Objectives for Cognitive Goal 2:**
Learn basic immunology related to allergic etiology and symptomatology.

1. Exhibit an understanding of basic immunology related to the Gell and Combs Classification with emphasis on Type I (IgE mediated) and Type III (Immune complex mediated) immunologic responses.
2. Exhibit knowledge of cellular and chemically mediated responses and their affect on symptom production.
3. Develop understanding of the principle of “total allergic load”.

**Objectives for Cognitive Goal 3:**
Learn concepts, specific etiologies and symptomatology of seasonal and perennial allergies.

1. Become familiar with seasonal allergens, their classification, and timing of pollination/prevalence.
2. Become familiar with local and regional environmental factors affecting antigenicity and potency of allergens.
3. Understand the multiple etiologies of perennial allergies.
4. Learn common allergic symptoms related to the ears, nose, mouth and throat and the head and neck region in general.

**Objectives for Cognitive Goal 4:**
Learn theory and principles of food related allergy, etiology and diagnosis.
1. Exhibit an understanding of fixed ("anaphylactic") food allergy, its causes and symptoms.
2. Exhibit an understanding of cyclic ("delayed") food allergy, its causes and symptoms.

Objectives for Cognitive Goal 5:
Expand knowledge about medications useful for the treatment of allergy, their indications, contraindications, appropriate dosing and side effects.
1. Become familiar with the proper patient selection, use and dosing of antihistamines, decongestants, mucolytics/expectorants, corticosteroids (oral and topical), leukotriene inhibitors, and other "allergy" medications.
2. Understand potential side effects and contraindications of allergy medications.

Objectives for Cognitive Goal 6:
Learn principles, techniques and indications for testing the suspected allergic patient.
1. Exhibit knowledge and understanding of allergy testing principles as they relate to skin reactivity (erythema and whealing) to allergens when applied topically, by prick method, intradermal injection and progressive dilutional testing.
2. Gain knowledge of different testing techniques including skin testing and in-vitro testing and the applications of each.
3. Understand indications for testing the suspected allergy patient and the indications and contraindications of specific testing techniques.

Objectives for Cognitive Goal 7:
Learn clinical indications for and immunomodulation principles of immunotherapy.
1. Exhibit understanding of when to recommend immunotherapy to the allergy patient.
2. Exhibit understanding of how immunotherapy affects the patient’s immune system and how it results in symptom control.

Objectives for Cognitive Goal 8:
Learn the signs, symptoms and treatment anaphylaxis.
1. Develop knowledge of the physical signs and symptoms of anaphylaxis and be able to differentiate them from those of the vasovagal reaction.
2. Develop knowledge of basic and advanced treatment methods for anaphylaxis.

Plastic / Reconstructive
Objective for Cognitive Goal 1:
Increase knowledge in anatomy of the head and neck
1. Be able to describe the anatomy of the skin
2. Be able to describe the anatomy of the craniofacial skeleton including buttresses and its relations to the underlying and overlying anatomic structures.
3. Be able to describe the vascular anatomy of the head, face and neck.
4. Be able to describe the facial musculature and SMAS
5. Be able to describe the sensory and motor nerve supply to the face
6. Attend to annual fresh cadaver dissection course pertinent to facial plastic and reconstructive surgery

Objective for Cognitive Goal 2:
Increase knowledge and skill in general evaluation of the patient who presents to the clinic with complaints related to facial plastic and reconstructive surgery.
1. Chief complaint of the patient.
2. History of physical illness or condition. Mechanism / etiology of facial deformity.
3. Past medical history
4. Past surgical history
5. Past social history
6. Family history
7. Allergies
8. Current medications
9. Systems review
10. Physical exam
   a. HEENT exam
   b. Exam specific to the patient’s chief complaint
11. Photodocumentation

Objective for Cognitive Goal 3:
Increase knowledge in basic principles in facial plastic and reconstructive surgery.
1. Increase knowledge in wound healing and wound care.
   a. Learn non-complicated wound care
   b. Learn complicated wound care
   c. Learn how to manage hypertrophic scars and keloids.
2. Increase knowledge and skill in basic soft tissue techniques.
   a. Elliptical excision and linear closure.
   b. M-plasty.
   c. Closure of the wounds with unequal edges by halving technique.
   d. Scar camouflage and revision.
      i. Multiple Z-plasties
      ii. Multiple W-plasty
      iii. Geometric broken line closure
   e. Z-plasty
   f. Suture techniques
      i. Standard interrupted or running
ii. Intracuticular
   iii. Vertical or horizontal mattress
   iv. Subcutaneous
   g. Use of staplers
   h. Use of Dermabond

3. Learn the difference in between various suture materials and their areas of use.
4. Increase skill in local anesthesia and nerve block techniques in the face.
5. Increase knowledge and skills in performing full thickness and split thickness skin grafts.
   a. Learn how to use a Padgett dermatome.
   b. Learn split thickness graft harvesting with scalpel.
   c. Learn how to apply a bolster on the skin graft.

Objective for Cognitive Goal 4:
Increase knowledge and skills in evaluation and management of maxillofacial trauma patient.
1. Increase knowledge and skill in evaluation of soft tissue injuries of the head and neck.
2. Be able to order appropriate radiological studies and increase knowledge in interpretation of these studies.
3. Learn to differentiate patient who will only need conservative management in a maxillofacial skeletal injury from a patient who will need open or closed reduction with or without fixation.
4. Learn dental occlusal relationships and maxillomandibular fixation (MMF) techniques. Also be able to distinguish between their indicated uses.
   a. Arch bar application
   b. Ivy loop application
   c. Screw MMF
   d. Rigid and elastic MMF
5. Increase knowledge and skills related to various cranio-maxillo-facial plating systems
   a. Learn the differences between various sizes of plates and their applications
   b. Learn to apply an external fixator
   c. Learn compression plating
   d. Learn locking plate application
   e. Learn lag screw fixation
6. Learn various surgical approaches to crani-maxillo-facial skeleton
   a. Coronal approach
   b. Gillies technique
   c. Lateral brow approach
   d. Upper blepharoplasty incision approach
   e. Subciliary approach
   f. Transconjunctival approach
g. Rhinoplasty approach
h. Upper gingivolabial/gingivobuccal approach
i. Lower gingivolabial/gingivobuccal approach
j. Transbuccal plating
j. Endoscopic approaches
k. Transcervical approach

7. Learn surgical treatment of various maxillofacial fractures
   a. Frontal sinus fractures
   b. Naso-orbito-ethmoid fractures
   c. Orbital floor fractures
   d. Zygomaticomaxillary complex
   e. LeFort fractures
   d. Mandibular fractures
8. Learn postoperative management, follow-up and rehabilitation of maxillofacial trauma patient.
9. Increase knowledge on complications and their management in maxillofacial trauma surgery.
10. Management of the airway in a trauma patient.

Objective for Cognitive Goal 5:
Learn reconstructive surgical techniques related to the defects in various portions of the face.
1. Increase knowledge in skin flap physiology and classification
2. Learn facial aesthetic subunit principles and relaxed skin tension lines and their practical values in reconstructive facial surgery
3. Learn cartilage graft harvesting techniques
   i. Auricular cartilage
   ii. Septal cartilage (in conjunction with septoplasty)
   iii. Costal cartilage
4. Learn bone graft harvesting techniques
   iv. Split calvarial bone graft
   v. Iliac crest
   vi. Tibial
5. Learn reconstructive techniques for nasal mucosal lining
    vii. Septal mucosal flap
    viii. Bipedicled nasal mucosal flap
    ix. Composite septal mucocartilaginous flaps
       1. Hett’s technique
       2. De Quervain’s technique
6. Increase knowledge on use of biologic and synthetic implants in reconstructive surgery
   x. Titanium mesh
   xi. Gold/titanium eyelid implants
   xii. Porous polyethylene
   xiii. Bone substitutes
   xiv. Silicon/silastic
xv. Absorbable polymers (PGA/PLA)
xvi. Polytetrafluoroethylene
xvii. Acellular human cadaveric dermis
xviii. Acellular porcine dermis
7. Increase knowledge on autogenous dermis, fat and fascia harvesting techniques and their applications
8. Increase knowledge of design, utilization and combination of various local flaps in facial reconstruction
  xix. O-T / A-T / O-H / V-Y and simple advancement flaps
  xx. Rhombic flap and its variations
  xxi. Bilobed flap and its variations
  xxii. Glabellar flap
  xxiii. Nasolabial flap (single-stage or two-stage)
  xxiv. Paramedian forehead flap (single-stage or two-stage)
  xxv. Cervicofacial advancement-rotation flap
    1. Mustarde
    2. Reverse Mustarde
9. Increase knowledge of design and utilization of frequently used regional flaps in head and neck reconstruction
    xxvi. Submental island flap
    xxvii. Deltopectoral flap
    xxviii. Pectoralis major flap with or without skin paddle
    xxix. Trapezius flap
10. Increase knowledge of planning and executing site specific reconstruction in the face
    xxx. Scalp
    xxxi. Nose
    xxxii. Cheek
    xxxiii. Lip
    xxxiv. Ear
11. Learn postoperative care and management of complications in patients who underwent reconstruction in head and neck
12. Increase knowledge of rehabilitation techniques in facial paralysis
    xxxv. Primary nerve repair
    xxxvi. Cable nerve grafting
    xxxvii. XII-VII anastomosis
    xxxviii. Masseter transposition
    xxxix. Temporal muscle transposition
      xl. Static facial slings
      xli. Tarsorrhaphy
      xlii. Implantation of gold weight to the upper eyelid
      xliii. Lower lid shortening techniques
13. Learn basic principles in tissue expansion

Objective for Cognitive Goal 6:
Increase knowledge of laser applications in the management of various
skin conditions.
1. Learn basic principles of laser physics and selective photothermolysis.
3. Learn preoperative considerations, indications, contraindications and postoperative skin care in laser treatments.
4. Learn laser safety precautions.
5. Learn how to operate various laser systems available at our institution and their areas of application.
   i. Erbium YAG laser in skin resurfacing.
   ii. Flash lamp pulsed dye laser for vascular lesions and hypertrophic scars.
   iii. Q-switch YAG laser and Q-switch Ruby laser for pigmented lesions, tattoos and hair removal.
   iv. Continuous wave KTP laser for telangiectasias.
   v. IPL for skin rejuvenation, rosacea and hair removal.
6. Learn other commercially available laser systems and their area(s) of application.
7. Increase knowledge on complications and their management in laser applications.

Objective for Cognitive Goal 7:
Increase knowledge and skill in evaluation and surgical or non surgical management of the patients with facial aesthetic concerns.
1. Learn aesthetic proportions of the face and facial analysis
2. Learn examination and evaluation of an aesthetic patient.
3. Learn how to present physical exam findings to the aesthetic patient.
4. Increase knowledge in basic skin care.
5. Learn patient selection in aesthetic surgery.
6. Increase knowledge on skin rejuvenation techniques.
7. Increase knowledge on injectable and filler materials and their applications.
   i. Botulinum toxin.
   ii. Injectable human or bovine collagen.
   iii. ePTFE.
   iv. Hyaluronic acid.
8. Increase knowledge on alloplastic facial augmentation materials and their applications.
   v. Cheek augmentation.
   vi. Chin augmentation.
9. Increase knowledge on advantages, disadvantages, indications, contraindications, risks, benefits, alternatives, preoperative considerations and postoperative care of various aesthetic surgical procedures.
   vii. Browlift
      1. Direct
      2. Midforehead
      3. Tricophytic
4. Bicoronal
5. Endoscopic

viii. Upper and lower blepharoplasty with or without orbital fat resection
   1. Skin muscle flap.
   2. Pinching.
   3. Transconjunctival.

ix. Facelift/midface lift

x. Septorhinoplasty
   1. Open
   2. Closed

xi. Increase knowledge on complications and their management in facial aesthetic surgery.

**Objective for Cognitive Goal 8:**
Improve in the ability to write for professional journals.
1. Reporting interesting cases.
2. Write review articles.
3. Publish case series or perform chart reviews for publication.
4. Conduct an original research project.
5. Work as a co-author in a publication project carried out by staff.

**Head and Neck**

**Objective for Cognitive Goal 1:**
Increase skill in performing the general and targeted head and neck history and review.
1. Be able to describe the elements of a complete and targeted head and neck history including the patient’s:
   i. Chief complaint
   ii. Current illness history
   iii. Allergies
   iv. Medications
   v. Previous surgeries
   vi. Pertinent social history and cultural background
2. Be able to review systems, emphasizing systemic conditions that may affect the head and neck.
3. Be able to efficiently conduct a complete and targeted head and neck history and systems review.
4. Be able to describe the elements of a complete head and neck oncology specialty outpatient clinical note.

**Objective for Cognitive Goal 2:**
Develop an intermediate to advanced level of knowledge of the analysis of preoperative risk factors that influence perioperative and intraoperative management of oncology patients.
1. Be able to outline the expected perioperative course for common head and neck procedures (listed in Objective for Cognitive Goal 8) and the indicators of potential complications that arise in the perioperative period. DVT Prophylaxis.

2. Be able to describe the nutritional assessment and nutritional support of head and neck cancer patients.

3. Be able to demonstrate an understanding of the management of perioperative patients in the intensive care unit including fluids, electrolytes, hemodynamic stability and ventilator management.

4. Be able to describe the incidence, identification, and management of potential complications associated with head and neck surgery including:
   i. Fistula
   ii. Facial paralysis
   iii. Dysphagia
   iv. Chronic Pain
   v. Aspiration
   vi. Aphonie
   vii. Bleeding and carotid rupture
   viii. Esophageal stenosis
   ix. Mucositis
   x. Shoulder weakness
   xi. Hypocalcemia and hypothyroidism

**Objective for Cognitive Goal 3:**
Increase skill in performing the head and neck examination.
1. Increase skill in using the fiberoptic and rigid laryngoscope.
2. Increase skill in performing mirror examination of the larynx.
3. Increase skill in physical examination of the head and neck.
4. Be able to describe the common and uncommon anomalies and conditions that may be encountered in the head and neck exam.

**Objective for Cognitive Goal 4:**
Increase skill in presenting new and established oncology patients in a concise and focused manner.
1. Be able to consistently present the patient’s history and the pertinent physical findings, putative diagnosis, and proposed management plan to staff in a concise and organized way.

**Objective for Cognitive Goal 5:**
Develop an intermediate to advanced level of knowledge of the surgical anatomy and physiology of head and neck neoplasia.
1. Be able to describe the TNM staging system for all head and neck locations.
2. Be able to describe and draw the anatomy of the larynx.
3. Be able to describe the development of the larynx with implications of tumor spread.
4. Be able to describe and draw the fascial spaces of the neck.
5. Be able to describe the current theory of cancer genetics.
6. Be able to describe the advantages of fine needle aspiration of head and neck masses.
7. Be able to describe the anatomy of the skull base and the various syndromes that are associated with tumor invasion of motor and sensory nerves.
8. Describe the most common lymphatic drainage basins for all the anatomic subsites.
9. Describe the five-year survival rates for various tumors and locations.
10. Describe how common chemotherapeutic agents and radiation kill cancer cells.

Objective for Cognitive Goal 6:
Increase knowledge of speech, digestive, and physical rehabilitative options for oncology patients.
1. Be able to describe the options and process of communicative and digestive rehabilitation after procedures that disrupt or remove oral, pharyngeal or laryngeal structures.
2. Be able to describe options for speech in patients with tracheostomies.
3. Describe the indications for physical rehabilitation in head and neck oncology patients.
4. Describe the indications for speech and language therapy….
5. Describe indications for pain management….

Objective for Cognitive Goal 7:
Develop an intermediate to advanced knowledge of the surgical, imaging/radiological, immunological, and chemotherapeutic options that are available for the diagnosis and treatment of head and neck neoplasia.
1. Be able to identify important features and landmarks of head and neck studies:
   a. Axial/coronal CT scan
   b. T1/T2 MRI
   c. Ultrasound
   d. PET imaging
   e. Angiography
   f. Lymphoscintigraphy / Sentinel node biopsy
   g. Barium swallow and MBS
2. Be able to describe the natural history, clinical presentation, evaluation, and general options for treatment of the following malignancies:
   a. Non-squamous cell cancers of the head and neck (salivary gland)
   l. Skin cancers
   m. Nasopharyngeal carcinoma
   n. Sinonasal carcinoma
   o. Oral cavity carcinoma
p. Oropharyngeal carcinoma
q. Hypopharyngeal carcinoma
r. Laryngeal carcinoma
s. Esophageal carcinoma
t. Thyroid and parathyroid cancers
u. Cervical metastases

Sleep Disorders

Objectives for Cognitive Goal 1:
Expand understanding of the evaluation and management of patients with SDB.
1. Be able to recognize the symptoms and physical signs in the SBD patient.
2. Be able to discuss the different aspects or stages of SBD from simple snoring to Pickwickian syndrome.
3. Be able to analyze physical findings and their implications in the SBD patient.
4. Be able to apply physical findings and diagnostic studies in the SBD patient in order to make appropriate medical or surgical treatment recommendations.

Objectives for Cognitive Goal 2:
Expand knowledge about medical and non-surgical options for management of Patients with SDB.
1. Understand medical options and their indications for managing SDB including physical measures such as weight loss, sleep positioning and supplemental oxygen.
2. Understand surgical options and their indications for managing SDB including CPAP and oral appliances.

Objectives for Cognitive Goal 3:
Learn surgical options for management of SDB, including indications, contraindications, risks and expected outcomes.
1. Gain knowledge of indications for tracheotomy, nasal and sinus surgery, maxillofacial/oral surgery, oropharyngeal surgery and tongue surgery as they relate to surgical management of SDB.
2. Learn specific indications for “in-office” (local anesthetic procedures such as LAUP, Somnoplasty and Palatal Implants) procedures useful for managing snoring, UARS and sleep apnea.
3. Understand the potential impact of “combination” procedures (i.e. nasal and oropharyngeal surgery, tongue and tongue base procedures and maxillofacial surgery) for treating SDB.
4. Be able to explain expected benefits, potential complications and other risks related to surgical procedures for SDB.

Objectives for Cognitive Goal 4:
Learn perioperative management of patients with SDB.
a. Gain and apply knowledge about disease specific operative risk factors in patients with SBD.

b. Gain and apply knowledge of postoperative care for the SDB patient including post-anesthetic complications of hypoventilation and cardiac dysrhythmia, post-operative monitoring and pain management.

c. Gain and apply knowledge of the indications for and timing of post-surgical polysomnogram studies.

Non-Cognitive Objectives:
University of Arkansas for Medical Science UAMS MC Hospital Rotation

Otology / Neurotology

Objective for Non-Cognitive Goal 1: Expand contact in the regional professional environment.
1. Be able to show evidence of implementation of a networking system.
2. Have and be able to demonstrate a system (card, computer, or other) for recording information about professional contacts.

Objective for Non-Cognitive Goal 2: Develop an understanding of professional practice in a specialty hospital environment, including an appreciation of the different styles of interacting with otologic \ neurotologic patients and their families.
1. Be able to demonstrate an appropriate approach to the evaluation of pediatric patients in the specialty clinic environment.

Objective for Non-Cognitive Goal 3:
Continue the habit of intermediate and long-term planning.

1. Have written one-year and five-year goals.

Allergy / Rhinology; Plastic / Reconstructive; Head and Neck

Objective for Non-Cognitive Goal 1:
Develop an understanding of the significant psychosocial, economic and physical stresses and their manifestations that life-threatening conditions have on patients and their families.

1. Be able to describe a variety of coping reactions that are commonly employed by patients with life threatening illnesses.
2. Be able to describe an appropriate therapeutic response for each of the common coping reactions that are employed by patients with life-threatening illnesses.
3. Demonstrate an understanding of how patients’ economic concerns may impact their decision making and compliance.
4. Be able to describe physical stresses that may impact a patient’s social environment.
Objective for Non-Cognitive Goal 2:
Develop an understanding of professional practice in a specialty hospital environment, including an appreciation of the different styles of interacting with head and neck cancer patients and their families.

1. Be able to demonstrate an appropriate approach to the evaluation of oncology patients in the specialty clinic environment.
2. Be able to describe appropriate responses to various levels of patient inquiries, comprehension and participation in their disease process.

Objective for Non-Cognitive Goal 3:
Develop skills in managing the psychosocial aspects of head and neck oncology patient care.

1. Be able to describe the ethical issues that are involved in the treatment of patients with life-threatening illnesses.
2. Be able to effectively communicate with patients and their families.

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<th>Technical Objectives</th>
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<td><strong>University of Arkansas for Medical Science UAMS MC Hospital Rotation</strong></td>
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**Otology / Neurotology**

**Objective for Technical Goal 1:**
Gain additional experience in otologic and neurotologic procedures.

1. Be able to efficiently perform tympanoplasty tube placement.
2. Be able to efficiently perform a simple tympanoplasty
3. Be able to efficiently perform a complete mastoidectomy

**Objective for Technical Goal 2:**
Gain experience in temporal bone drilling.

1. Develop surgical drilling skills through supervised cadaveric temporal bone drilling in temporal bone laboratory on a regularly scheduled basis.
2. Develop clinical and surgical skills to allow safe and effective surgical treatment of otologic diseases under the supervision of the attending otologist/neurotologist.

**Allergy / Rhinology**

**Objectives for Technical Goal 1:**
1. Learn to interpret symptoms and physical signs of inhalant allergy.
2. Develop basic and advanced history skills in order to recognize the common symptoms of otolaryngic allergy.
3. Develop basic and advanced physical exam techniques to recognize common physical signs of otolaryngic allergy.
Objectives for Technical Goal 2:
Learn techniques for inhalant allergy testing. Gain practical experience with basic skin testing techniques and interpretation by observing and performing prick, intradermal and dilutional techniques in the clinic and laboratory setting. Learn in-vitro testing techniques (with emphasis on RAST-type) and be able to interpret results. Apply knowledge of etiologic factors of inhalant allergy to techniques of environmental control and avoidance measures.

Objectives for Technical Goal 3:
Learn application of avoidance and medical management for inhalant allergies.
1. Understand and recommend allergy avoidance measures, including environmental controls measures, for the treatment of inhalant allergies.

Objectives for Technical Goal 4:
1. Learn methods for diagnosis and treatment of fixed and cyclic food allergy.
2. Recognize methods of diagnosing fixed food allergies to include detailed history and in-vitro testing for IgE mediated reactions and principles of avoidance.
3. Recognize the major steps in the food allergy “cycle” and be able to apply them in the clinical setting.
4. Be able to utilize the Elimination/Challenge test for the diagnosis of cyclic food allergy in the clinical setting.
5. Understand and be able to apply use of the Rotary Diversified diet in the management of cyclic food allergies.

Objective for Technical Goal 5:
Learn techniques necessary for providing immunotherapy.
1. Apply skin and in-vitro testing results for application to immunotherapy treatment.
2. Prepare skin testing treatment boards.
4. Perform and interpret vial tests.
5. Administer allergy shots to patients.
6. Manage immunotherapy dose escalation.
7. Understand maintenance immunotherapy.
8. Understand problem solving during immunotherapy.
9. Attend didactic and Hands-on otolaryngic allergy courses as possible.

Plastic / Reconstructive

Objective for Technical Goal 1:
Learn alternative or different techniques in the surgical or non-surgical management of a given condition in facial plastic and reconstructive surgery.
1. Follow professional journals on facial plastic and reconstructive surgery
2. Take instructional courses in AAOHNSF and/or AAFPRS meetings
3. Read specific textbooks and atlases
4. Watch videos or DVDs recorded by other surgeons

**Head and Neck**

**Objective for Technical Goal 1:**
Gain additional experience in a wide range of head and neck oncological procedures.
1. Obtain experience in the design and transfer of myocutaneous flaps.
2. Gain appreciation in the design, harvest and inset and indication for microvascular flaps.
3. Gain experience in the design and reconstruction of soft tissue and osseous defects.
4. Gain experience in surgical rehabilitation of the voice, including primary and secondary tracheoesophageal puncture.

**Objective for Technical Goal 2:**
Obtain an intermediate level of skill in head and neck oncological procedures.
1. Be able to appropriately plan and mark surgical incisions.
2. Be able to technically raise surgical flaps.
3. Be able to safely and efficiently perform a tracheostomy.
4. Be able to appropriately select and close surgical defects using local and regional flaps.
5. Be able to safely and appropriately complete the majority of surgical oncologic operations, including:
   - Composite resection of the oral cavity tumors
   - Neck dissections
   - Cricopharyngeal myotomy / pharyngeal diverticulectomy
   - Pharyngectomy
   - Pharyngotomy
   - Maxillectomy
   - Partial and total glossectomy
   - Partial and total laryngectomy (open and laser resection)
   - Thyroidectomy
   - Parathyroidectomy
   - Parotidectomy

**Sleep Disorders**

**Objectives for Technical Goal 1:**
Learn skills with surgical techniques for SDB.

1. Develop basic and advanced surgical techniques and skills with tracheotomy, nasal surgery (including septoplasty and turbinate reduction), tonsillectomy, uvulopalatopharyngoplasty, genioglossus advancement and hyoid suspension.
2. Develop surgical techniques and basic skills for “in-office” (local anesthetic) procedures such as Laser Assisted Uvulopalatoplasty, Somnoplasty and Palatal Implants.

Objectives for Technical Goal 2:
Learn Skills understanding Polysomnogram (PSG) summary results.

1. Recognize and apply PSG summary results including sleep stage analysis, oxy-hemoglobin saturation measurements, hypopneas, apneas, and RDI/AHI.
2. Recognize and apply PSG summary results related to application of Continuous Positive Airway Pressure (CPCP) trials.

ACH - ARKANSAS CHILDREN’S HOSPITAL ROTATION:
GOALS AND OBJECTIVES

Introduction

The fundamental focus for this resident rotation is expanded clinical experience and depth in diagnosis and treatment of pediatric otolaryngology conditions. Principles of diagnosis and treatment are taught progressively and continuity of care is emphasized. This rotation gives residents in-depth experience with the diagnosis and management of pediatric otolaryngology problems including pediatric airway, general pediatric otolaryngology, pediatric ear disease, obstructive sleep apnea, cleft lip and palate, vascular anomalies, and pediatric voice and swallowing disorders.

The otolaryngology resident will be supervised and instructed by staff pediatric otolaryngologists. When Fellows or more senior residents are present on the service a hierarchical system will prevail, with the junior resident reporting to the senior resident or chief resident of the surgical team, who in turn reports to the attending staff. It is expected that, until delegated more authority, the junior resident will discuss all issues with the chief resident or attending staff. Senior residents and attending surgical staff will be available in a rapid reliable manner. Delegation of authority and responsibility for patient care will increase as the resident demonstrates increased competence in the delivery of safe, effective, and compassionate care. The pediatric otolaryngology staff will formally evaluate each otolaryngology trainee’s performance at the end of the rotation.
The organization, including the Program Requirements and Duties in Pediatric Otolaryngology performed at the ACH - Arkansas Children’s Hospital teaching service(s) and clinic(s) are as follows:

Residents on the pediatric otolaryngology rotation at Arkansas Children’s Hospital are provided a comprehensive education in medical and surgical care of patients with diseases and disorders that affect the ears, the upper respiratory and upper alimentary systems and related structures of the head and neck, in the pediatric age group. Presently, ACH has three full-time pediatric otolaryngologists. Our full-time pediatric fellowship was established in 1994.

The housestaff consists of two to five pediatric otolaryngology residents (including the otology resident) and one fellow on service. Pediatrics residents and medical students rotate on the service, as well.

The resident should gain clinical, surgical, and case management knowledge for pediatric patients in several areas during this rotation: general ENT, airway management, cleft lip and palate, sinus disease, allergy, trauma, facial plastic and reconstructive surgery, otology/neurotology, laser surgery, endoscopy and voice disorders. Otolaryngology residents are responsible for 50% of the patients in clinics, 80% of patients in the OR and 100% of hospital in-patient care. Residents are 100% under the direction of a staff physician at all times regarding patient care.

In addition to the general program requirements listed above, residents at ACH are expected to attend pediatric specialty conferences. At a minimum, residents should attend the weekly pediatric otolaryngology case conference and lecture series on Monday mornings. Residents are encouraged when time allows to attend specialty conferences in cleft lip/palate and vascular malformations and sleep apnea. Pediatric subspecialty conferences should also be attended when presented.

Curriculum

Reading Assignments:

Practical Pediatric Otolaryngology by Cotton, 1st ed 1998
Home Study Course by the American Academy of Otolaryngology

Products:
1. Required submission of tests from the Home Study Course.
2. Participation in resident case presentations held every Monday AM
3. Participation in research as delineated in the research policy

Goals

Cognitive Goals – ACH - Arkansas Children’s Hospital
(ACGME Goals: Medical Knowledge, Patient Care & System-Based Learning)
1. Increase skill in performing the head and neck examination of the pediatric patient.
2. Increase skill in performing the general and targeted head and neck history and systems review.
3. Increase skill in presenting new and established patients in a concise and focused manner.
4. Increase skill in the diagnosis and management of patients who present to the pediatric otolaryngology clinic.
5. Increase knowledge about the indications, contraindications, and risks of pediatric surgical procedures; also learn the alternatives to such procedures.
6. Learn the perioperative management of surgical patients who present to the pediatric otolaryngology clinic.
7. Expand knowledge of pediatric diagnostic radiology.
8. Expand knowledge of the anatomy and embryology of the pediatric head and neck.
9. Acquire core knowledge in pediatric otolaryngology through book reviews and departmental educational activities.
10. Improve in the ability to write for professional journals.

**Non-Cognitive Goals ACH - Arkansas Children’s Hospital**  
(ACGME Goals: Interpersonal/Communication; Professionalism, Practice-based Learning)

1. Expand contacts in the regional professional environment.
2. Develop an understanding of professional practice in a specialty hospital environment, including an appreciation of the different styles of interacting with pediatric patients and their parents.
3. Continue the habit of intermediate and long-term planning.

**Technical Goals – ACH - Arkansas Children’s Hospital**  
(ACGME Goals: Medical Knowledge, Patient Care)

1. Gain additional experience in basic pediatric otolaryngology procedures.
2. Gain experience in pediatric endoscopy.
3. Gain skills in pediatric facial plastics procedures.

**Objectives/Cognitive - ACH - Arkansas Children’s Hospital**

Objectives for Cognitive Goal 1:
Increase (through supervised patient encounters in the outpatient clinics) skill in performing the head and neck examination of the pediatric patient.

1. Increase skill in the use of fiberoptic nasopharyngoscopy, indirect laryngoscopy, microscopic otoscopy, and pneumatic otoscopy and increase in the knowledge of abnormal anatomy.
2. Be able to describe the elements of a complete pediatric specialty head and neck outpatient clinical note.
3. Be able to describe the common and uncommon anomalies and conditions that may be encountered in the pediatric head and neck exam.
Objectives for Cognitive Goal 2:
Increase skill in performing the general and targeted head and neck history and systems review.

1. Be able to describe the elements of a complete and targeted pediatric head and neck history including the patient’s
   a. chief complaint
   b. current illness history
   c. allergies
   d. current medications
   e. previous operations, hospitalizations
   f. pertinent social history and cultural background
   g. psychosocial level of development
2. Be able to review systems, emphasizing systemic conditions that may affect the head and neck.
3. Be able to efficiently conduct a complete and targeted head and neck history and systems review including the elements that are described above in Objective 1.

Objectives for Cognitive Goal 3:
Increase skill in presenting new and established patients in a concise and focused manner—Be able to consistently present the patient’s history and the pertinent physical findings, putative diagnosis, and proposed management plan to staff in a concise and organized way.

Objectives for Cognitive Goal 4:
Increase skill in the diagnosis and management of patients who present to the pediatric otolaryngology clinic.

1. Be able to discuss management of various pediatric facial fractures/trauma.
2. Be able to interpret an audiogram and know the appropriate technique to obtain audiologic information based on the patient’s age.
3. Be able to describe the natural history, clinical presentation, and evaluation of otitis media and any treatment options.
4. Be able to describe the potential complications of acute otitis media and management options for each complication.
5. Know the appropriate medications for acute and chronic otitis media and be able to explain bacteriology and the patterns of resistance that influence the selection of antibiotics.
6. Be able discuss considerations in reconstruction of congenital ear disorders, i.e., microtia, canal atresia.
7. Be able to describe the appropriate pediatric audiologic interventions (hearing aids, etc.) based on the patient’s age and audiologic situation.
8. Be able to efficiently evaluate pediatric patients with airway complaints such as subglottic stenosis and laryngomalacia.
9. Be able to describe the evaluation of blunt laryngeal trauma in the
pediatric age group.
10. Be able to describe the appropriate management of pediatric airway emergencies, including epiglottitis.
11. Be able to describe the etiology and evaluation of bilateral vocal cord paralysis.
12. Be able to describe the types and natural histories of pediatric laryngeal neoplasms.
13. Be able to describe the evaluation of gastro-esophageal reflux disease (GERD) and its manifestations.
14. Be able to describe the anatomy and pathophysiology of developmental anomalies of the neck (e.g., branchial cleft fistulae).
15. Be able to do an appropriate evaluation of a pediatric patient who has head and neck masses and cervical adenopathy.
16. Be able to describe the evaluation of pediatric rhinosinusitis and allergy.
17. Be able to differentiate between types of vascular anomalies.
18. Be able to describe different with types of cleft lip and palate, craniofacial anomalies and syndromes.
19. Be able to describe sleep disorders, their evaluation, and treatment options.

Objectives for Cognitive Goal 5:
Increase knowledge about the indications and contraindications of pediatric surgical procedures, the risks of such procedures, and alternative treatments.

1. Be able to describe the surgical options for the treatment of otitis media, including the indications and risks of such options and the alternatives to surgery.
2. Be able to describe the surgical options for complicated pediatric rhinosinusitis.
3. Be able to describe the surgical options for treating laryngomalacia.
4. Be able to describe the surgical options for treating subglottic stenosis.
5. Be able to describe the surgical options for treating vocal cord paralysis.
6. Be able to describe the surgical options for treating laryngeal papillomatosis.
7. Be able to describe the surgical options for treating nasal angiofibroma.
8. Be able to describe the surgical treatment of neck masses depending on their etiology.
9. Be able to discuss appropriate surgical management of all type of vascular anomalies.
10. Be able to describe procedures and considerations when planning repair of cleft lip/palate as well as reconstruction for velopharyngeal insufficiency and other craniofacial anomalies.
11. Be able to describe the procedures for sleep disorders.
Objectives for Cognitive Goal 6:
Learn the perioperative management of patients who present to the pediatric otolaryngology clinic—Be able to outline the expected perioperative course for common pediatric otolaryngology procedures and the indicators of potential complications that arise in the perioperative period including

1. myringotomy and tympanostomy tube placement
2. tympanoplasty
3. tracheotomy
4. laryngoscopy
5. bronchoscopy
6. esophagoscopy
7. endoscopic sinus surgery (FESS)
8. arytenoidectomy/arytenoidpexy
9. laryngotracheoplasty/cricoid split
10. excision of nasopharyngeal angiofibroma
11. tonsillectomy and adenoidectomy
12. cutaneous laser treatments of vascular anomalies
13. Repair cleft lip/palate
14. facial fracture repair – closed reduction/open reduction
15. surgery for velopharyngeal insufficiency

Objectives for Cognitive Goal 7:
1. Expand knowledge of pediatric diagnostic radiology of the head and neck.

2. Understand the diagnostic modalities that are used in evaluation of the upper aerodigestive tract including the different techniques that are used to evaluate the potential of foreign bodies in the pediatric age group.

3. Be able to identify important features and landmarks of pediatric head and neck studies:
   a.) axial/coronal CT scan
   b.) T1/T2 MRI scan
   c.) ultrasound

4. Be able to identify the classic appearance of epiglottis as shown on the lateral neck film.

5. Be able to identify the classic appearance of laryngotraheal bronchitis as shown on the AP neck film.

6. Understand the role of various radiologic procedures for diagnosis as well as treatment of various vascular anomalies.
Objectives for Cognitive Goal 8:
Expand knowledge of the anatomy and embryology of the pediatric head and neck.

1. Be able to describe the surgical anatomy of the pediatric larynx and cricoid.
2. Be able to describe the embryology of the larynx and cricoid.
3. Be able to describe the surgical anatomy of the pediatric trachea.
4. Be able to describe the embryology of the trachea.
5. Be able to describe the surgical anatomy of the pediatric paranasal sinuses.
6. Be able to describe the embryology of pediatric sinuses.
7. Understand the embryology of cleft lip/palate.
8. Understand the embryology of the developing neck including thyroid, and branchial apparatus.

Objectives for Cognitive Goal 9:
Acquire core knowledge in pediatric otolaryngology through book reviews and departmental educational activities.

1. Prepare for resident case presentations each Monday am, with small topic review for each case. Resource: Practical Pediatric Otolaryngology by Cotton, 1st ed 1998.

Objectives for Cognitive Goal 10:
Improve in the ability to write for professional journals.

Actively engage in research according to the department research policy.

Objectives/Non-Cognitive - ACH - Arkansas Children’s Hospital
Objectives for Non-Cognitive Goal 1:
Be able to show evidence of implementation of a networking system

1. Have, and be able to demonstrate, a system (card, computer, or other) for recording information about professional contacts.

Objectives for Non-Cognitive Goal 2:
Develop an understanding of professional practice in a specialty hospital environment, including an appreciation of the different styles of interacting with pediatric patients and their parents.

3. Be able to demonstrate an appropriate approach to the evaluation of pediatric patients in the specialty clinic environment.

Objectives for Non-Cognitive Goal 3:
Develop the habit of intermediate and long term planning.

1. Have written one-year and five-year goals.
Objectives/Technical – ACH - Arkansas Children’s Hospital

Objectives for Technical Goal 1:
Gain additional experience in basic pediatric otolaryngology procedures.

1. Be able to efficiently perform an adenotonsillectomy.
2. Be able to efficiently perform tympanostomy/tube placement.
3. Be able to perform basic endoscopic sinus surgery (anterior ethmoidectomy and opening of the osteomeatal complex)
4. Be able to secure pediatric airway

Objectives for Technical Goal 2:
Gain experience in pediatric endoscopy—Develop clinical and surgical skills to allow the thorough evaluation and management of pediatric patients with compromised airway (inflammatory, congenital, acquired disorders) under the supervision of the attending pediatric otolaryngologist. Be able to perform a pediatric:

1. laryngoscopy
2. bronchoscopy
3. esophagosphy

Objectives for Technical Goal 3:

1. Be able to discuss/plan various flap, repair techniques in reconstructing cleft lip/palate wounds, and excisions of head and neck masses.
2. Be able to excise and close wounds using facial plastic techniques.

CAVHS - Central Arkansas Veterans Healthcare System
VA Hospital Rotation: Goals and Objectives

Introduction
The fundamental focus of the CAVHS resident rotation is expanded clinical experience and depth in diagnosis and treatment of adult otolaryngology conditions, building on the previous experience of earlier postgraduate years. The CAVHS chief resident is expected to have in-depth knowledge of the diagnosis and treatment of otolaryngologic conditions. This rotation provides residents with an in-depth experience in the diagnosis and management of sinonasal disease, neuro-otologic disorders, head and neck neoplasms, facial plastic and reconstructive surgery, voice disorders and other areas of general otolaryngology. The chief resident on the CAVHS rotation is expected to further refine their knowledge base by actively reading and participating in the education of the junior resident.
The length of this rotation provides continuity of care experiences, whereby the residents are responsible for preoperative evaluation and management, surgical treatment under the supervision of the staff physicians and postoperative management and discharge of patients. The residents will frequently see patients they cared for during the perioperative period on followup clinic.

The otolaryngology resident will be constantly supervised by the attending staff, which has clinical expertise in the aforementioned areas of subspecialty focus. When more senior residents are present on the service a hierarchical system will prevail, with the junior resident reporting to the senior resident or chief resident of the surgical team, who in turn reports to the attending staff. It is expected that, until delegated more authority, the junior resident will discuss all issues with the chief resident and attending staff. Senior residents and attending surgical staff will be available in a rapid reliable manner. Delegation of authority and responsibility for patient care will increase as the resident demonstrates increased competence in the delivery of safe, effective, and compassionate care. The attending staff will formally evaluate each otolaryngology trainee’s performance at the end of the CAVHS rotation.

The organization, including the Program Requirements and Duties of the CAVHS – Central Arkansas Veterans Healthcare System – VA Hospital teaching service(s) and clinic(s) are as follows:

This service offers an outstanding experience for resident training and education. Residents in their PGY-5, PGY-4 and PGY-3 year, rotate at the VA each year. There is full staff coverage in all subspecialties of otolaryngology, including otology/neurotology, facial plastic and reconstructive surgery, head and neck oncologic surgery, endoscopic sinus surgery, skull base surgery, microvascular reconstruction, laryngology and endoscopy. Two advanced practice nurses (APNs) help with coordination of patient care. The outpatient clinics are busy and offer a large volume of patients with a wide variety of clinical problems.

The VA rotation offers the residents an opportunity to exercise some autonomy in managing clinical problems. In addition, the residents have the opportunity to develop some increased responsibility in the operating room. This increased autonomy and responsibility is dependent on the resident’s experience and is done under direct staff supervision.

Residents should gain clinic, surgical, and case management knowledge for adult patients in several areas during this rotation including head and neck oncology, skull base surgery, thyroid, sinus disease, allergy, trauma, facial plastic and reconstructive surgery, otology/neurotology, laser surgery, voice, general ENT, and endoscopy.
The resident interfaces directly with providers in audiology, speech pathology, radiology, pathology, and other rehabilitative services. Clinics are held 4.5 days per week and operative cases are done 4.5 days per week. Otolaryngology residents are responsible for 80% of patients in the clinics, 100% of patients in the O.R. and 100% of hospital in-patient care. Residents are 100% under the direction of staff physician’s at all times regarding patient care.

The PGY3 resident is responsible for in-patient care. They take an increasingly larger role in the operation room doing cases that require more skill and judgment. The staff or more senior residents are available at all times in the operating room. They also take a larger role in the clinic and are expected to manage level appropriate clinical problems. The PGY4 resident performs essentially the same functions as the PGY3 resident. Roles in the clinic and operating rooms increase over the PGY3 level commensurate with skill. The PGY5 resident is in charge of the VA service and helps supervise the ward. They make most of the decisions on overall patient management in consult with the staff. They perform the most complex operative procedures with staff supervision. They are in charge of clinic and review most patients requiring surgical intervention.

Curriculum

Reading Assignments:
Home Study Course by the American Academy of Otolaryngology
Select peer review articles from Otolaryngology journals - monthly

Supplemental Reading:
Cancer of the Head & Neck by Meyers and Suen
Atlas of Head and Neck Surgery by Lore and Medina
Facial Plastic and Reconstructive Surgery by Papel, Frodel, Holt, Larrabee, Nachlas, Park, Sykes and Toriumi
Head and Neck Pathology with Clinical Correlation by Wenig
Imaging of the Head and Neck, Mafee, et al,2005

Products
1. Required submission of tests from the Home Study Course
2. Oral presentation of interesting cases as they present to the CAVHS clinic at weekly morning conference
3. Oral presentation of head and neck cancer cases at quartery CAVHS Multidisciplinary Cancer Conference

Conferences
1. Multidisciplinary Head and Neck Tumor Conference - Weekly
2. Morbidity and Mortality Conference – 2 times per month
## Goals

<table>
<thead>
<tr>
<th>Cognitive Goals - CAVHS - Central Arkansas Veterans Healthcare System (CAVHS) – VA Hospital Rotation</th>
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<tbody>
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<td>1. Increase skill in the diagnosis and management of patients who present to the veteran’s hospital otolaryngology clinic.</td>
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<tr>
<td>2. Expand knowledge about indications, contraindications, risks, and surgical options of facial plastic, sinonasal and airway, head and neck oncologic and otologic procedures and alternative to such procedures.</td>
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<tr>
<td>3. Develop an intermediate to advanced level of knowledge of the analysis of preoperative risk factors that influence perioperative and intraoperative management of patients.</td>
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<td>4. Increase knowledge of audiologic, speech, digestive, and physical rehabilitative options.</td>
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<tr>
<td>5. Develop an intermediate to advanced knowledge of the surgical, radiological and therapeutic options that are available for the treatment of head and neck neoplasia, neuro-otologic disorders, facial plastic and reconstructive conditions, and general otolaryngology problems.</td>
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<tr>
<td>1. Obtain a comprehensive understanding and appreciation of practice based learning in Otolaryngology.</td>
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<tr>
<td>2. Gain a comprehensive understanding and appreciation of the role of professionalism in Otolaryngology.</td>
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<tr>
<td>3. Develop an understanding of professional practice in a veteran’s hospital environment, including an appreciation of the different styles of interacting with veteran patients and their families.</td>
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<tr>
<td>4. Further develop and apply interpersonal and communication skills with patients, peers and staff including other departments or divisions</td>
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<td><strong>(ACGME Goals: Medical Knowledge, Patient Care, &amp; System-Based Learning)</strong></td>
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<tr>
<td>1. Gain expertise in intermediate to advanced facial plastic and reconstructive surgical procedures.</td>
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<tr>
<td>2. Gain expertise in intermediate to advanced otologic procedures.</td>
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<td>3. Gain expertise in sinonasal procedures.</td>
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<td>4. Gain expertise in airway procedures.</td>
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<tr>
<td>5. Gain expertise in intermediate to advanced head and neck oncologic procedures.</td>
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</table>
Objectives/Cognitive

Objective for Cognitive Goal 1:
Increase skill in the diagnosis and management of patients who present to the veteran’s hospital otolaryngology clinic.

1. Be able to efficiently conduct a complete and targeted head and neck history and systems review.
2. Be able to describe the diagnostic criteria and management for the aging face, sinusitis, airway disorders, inner ear related dizziness and head and neck cancers.

Objective for Cognitive Goal 2:
Expand knowledge about contraindications, risks, and surgical options of facial plastic, sinonasal, airway and swallowing, head and neck oncologic and otologic procedures and alternative to such procedures.

Facial plastic procedures:
- Blepharoplasty
- Rhinoplasty
- Browlift
- Submentoplasty
- Rhytidectomy
- Maxillomandibular fixation and open reduction of facial fractures
- Facial paralysis rehabilitation
- Scar revision

Sinonasal procedures:
- Functional endoscopic sinus surgery
- Image guided endoscopic sinus surgery
- Septoplasty

Airway and swallowing procedures:
- Adenoidectomy and tonsillectomy
- Uvulopalatopharyngoplasty
- Tracheostomy
- Tracheal resection
- Vocal cord augmentation and medialization
- Esophagoscopy and dilation

Head and neck procedures:
- Composite resection of the oral cavity tumors
- Neck dissections
- Cricopharyngeal myotomy
- Pharyngectomy
- Pharyngotomy
- Maxillectomy
- Partial and total glossectomy
- Partial and total laryngectomy
- Thyroidectomy
Parathyroidectomy  
Parotidectomy

**Otologic procedures:**
- Myringotomy and tympanostomy tube placement
- Tympanoplasty
- Mastoidectomy

**Objective for Cognitive Goal 3:**
Develop an intermediate to advanced level of knowledge of the analysis of preoperative risk factors that influence perioperative and intraoperative management of otolaryngology patients.

1. Be able to outline the expected perioperative course for common procedures (listed in Objective for Cognitive Goal 2) and the indicators of potential complications that arise in the perioperative period.
2. Be able to describe the nutritional assessment and nutritional support of elderly and head and neck cancer patients.
3. Be able to demonstrate an understanding of the management of perioperative patients in the intensive care unit including fluids, electrolytes, hemodynamic stability and ventilator management.
4. Be able to describe the incidence, identification, and management of potential complications associated with procedures in each of the subspecialty areas.

**Objective for Cognitive Goal 4:**
Increase knowledge of audiologic, speech, digestive, and physical rehabilitative options.

1. Be able to interpret an audiogram and auditory brainstem evoked response test (ABR).
2. Be able to describe the appropriate audiologic interventions such as hearing aids, based on the patient’s audiologic situation.
3. Be able to describe the options and process of communicative and digestive rehabilitation after procedures that disrupt or remove oral, pharyngeal or laryngeal structures.
4. Be able to describe options for speech in patients with tracheostomies.
5. Describe the indications for physical rehabilitation in head and neck oncology patients and vestibular rehabilitation in the dizzy patient.

**Objective for Cognitive Goal 5:**
Develop an intermediate to advanced knowledge of the surgical, radiological and therapeutic options that are available for the treatment of head and neck neoplasia, neuro-otologic disorders, facial plastic and reconstructive conditions, and general otolaryngology problems.

1. Be able to identify important features and landmarks of imaging studies:
   a. Axial/coronal CT scan
   b. T1/T2 MRI
c. Ultrasound

d. PET imaging

e. Angiography

f. Lymphoscintigraphy

g. Barium swallow and MBS

2. Be able to describe the natural history, clinical presentation, evaluation, and general options for treatment of the following conditions:

a. Dizziness
   i. Benign Paroxysmal Positional Vertigo (BPPV)
   ii. Meniere’s disease
   iii. Vestibular neuritis
   iv. Superior canal dehiscence
   v. Perlilymphatic fistula
   vi. Multisensory disorder
   vii. Postural hypotension / vascular
   viii. CNS causes

b. Sinusitis
   ix. Acute sinusitis
   x. Chronic sinusitis
   xi. Fungal sinusitis
   xii. Sinus headache
   xiii. Nasal polyposis
   xiv. Cerebral spinal fluid leak

c. Airway and swallow disorders
   xv. Vocal cord nodules
   xvi. Reflux laryngitis
   xvii. Vocal cord paralysis
   xviii. Dysphonia
   xix. Renke’s edema
   xx. Vocal cord atrophy
   xxi. Esophageal stricture
   xxi. Cricopharyngeal spasm
   xxi. Dysphagia

d. Head and neck cancers
   xxiv. Non-squamous cell cancers of the head and neck
   xxv. Skin cancers
   xxvi. Nasopharyngeal carcinoma
   xxvii. Sinonasal carcinoma
   xxviii. Oral cavity carcinoma
   xxix. Oropharyngeal carcinoma
   xxx. Hypopharyngeal carcinoma
   xxxi. Laryngeal carcinoma
   xxxii. Esophageal carcinoma
   xxxiii. Thyroid and parathyroid cancers
   xxxiv. Cervical metastases

e. Nasal deformities
Objective/Non-Cognitive CAVHS - Central Arkansas Veterans Healthcare System (CAVHS) – VA Hospital Rotation

Objective for Non-Cognitive Goal 1:
Obtain a comprehensive understanding and appreciation of practice based learning in Otolaryngology.

1. Be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

Objective for Non-Cognitive Goal 2:
Gain a comprehensive understanding and appreciation of the role of professionalism in Otolaryngology.

1. Consistently display leadership to the team by demonstrating behaviors that reflect a commitment to continuous professional development, ethical practice, understanding and sensitivity to diversity and a responsible attitude towards patients and society.

Objective for Non-Cognitive Goal 3:
Develop an understanding of professional practice in a veteran’s hospital environment, including an appreciation of the different styles of interacting with veteran patients and their families.

1. Be able to describe appropriate responses to various levels of patient inquiries, comprehension and participation in their disease process.

Objective for Non-Cognitive Goal 4:
Further develop and apply interpersonal and communication skills with patients, peers and staff.

1. Be able to effectively communicate with patients and their families.
2. Displays leadership to the team by demonstrating interpersonal and communication skills that establish and maintain professional relationships with patients, families, and other members of the healthcare team.
Objective/Technical

Objective for Technical Goal 1: Gain expertise in intermediate to advanced facial plastic and reconstructive surgical procedures.

1. Blepharoplasty
2. Rhinoplasty
3. Browlift
4. Submentoplasty
5. Rhytidectomy
6. Maxillomandibular fixation and open reduction of facial fractures
7. Facial paralysis rehabilitation
8. Local and myocutaneous flap reconstruction
9. Scar revision

Objective for Technical Goal 2:
Gain expertise in intermediate to advanced otologic procedures.

1. Myringotomy and tympanostomy tube placement
2. Tympanoplasty
3. Mastoidectomy
4. Labyrinthectomy
5. Endolymphatic sac surgery
6. Transtympanic craniotomy
7. Retrosigmoid craniotomy
8. Middle fossa craniotomy
9. Canaloplasty
10. Meatoplasty
11. Intratympanic gentamicin

Objective for Technical Goal 3
Gain expertise in sinonasal procedures.

1. Functional endoscopic sinus surgery
2. Maxillary antrostomy
3. Ethmoidectomy
4. Sphenoidotomy
5. Frontal sinusotomy
6. Image guided endoscopic sinus surgery
7. Polypectomy
8. Septoplasty
9. Turbinate reduction or trim

Objective for Technical Goal 4
Gain expertise in airway and swallow procedures.
1. Adenoidectomy and tonsillectomy
2. Uvulopalatopharyngoplasty
3. Tracheostomy
4. Tracheal resection
5. Glottic and subglottic resection
6. Microlaryngoscopy with and without CO2 laser
7. Vocal cord augmentation and medialization
8. Esophagoscopy and dilation

Objective for Technical Goal 5
Obtain an intermediate level of skill in head and neck oncological procedures.

1. Be able to appropriately plan and mark surgical incisions.
2. Be able to technically raise surgical flaps.
3. Be able to safely and efficiently perform a tracheostomy.
4. Be able to appropriately select and close surgical defects using local and regional flaps.
5. Be able to safely and appropriately complete the majority of surgical oncologic operations, including
   a. Composite resection of the oral cavity tumors
   b. Neck dissections
   c. Cricopharyngeal myotomy
   d. Pharyngectomy
   e. Pharyngotomy
   f. Maxillectomy
   g. Partial and total glossectomy
   h. Partial and total laryngectomy
   i. Thyroidectomy
   j. Parathyroidectomy
   k. Parotidectomy
PGY 1

Goals and Objectives

PGY 1 Resident:
The PGY1 level of residency is complex in its structure and its description requires a breakdown of each individual month of the 12 month cycle.

Currently there are three (3) PGY 1 Otolaryngology Residents, each of which rotates through the various ABOTO required services during the 12 months of training. The following is a list of the surgery and related specialty rotations offered.

Rotation Outline:

5 months General Surgery and related specialties
- 2 in pediatric surgery
- 1 in plastic surgery
- 2 in general surgery

4 months (1 month of each) ENT related specialties
- Anesthesia
- SICU
- Emergency Medicine
- Neurosurgery

3 Months of ENT
- 3 months ENT
The main goal of this rotation is to provide the PGY1 general surgery resident a 2 month rotation to enable him/her to acquire the basic knowledge and skills in the evaluation and management of surgical patients.

By the completion of PGY 1, the resident should be knowledgeable in the following areas and be able to perform:

**History and Physical Examination, Documentation**
Obtain a detailed surgical history and obtain and review relevant medical records and reports
Perform a detailed physical examination.
  - Develop a complete differential diagnosis.
  - Maintain a personal patient log.
  - Write a succinct H&P, including a risk assessment evaluation.
  - Obtain a written informed consent.
  - Document the treatment plan in the medical record, including the indications for treatment.
  - Dictate an operative note and discharge summary.

**Patient Assessment and Preoperative Management**
Order and interpret basic laboratory tests and screening X-Rays, and evaluate the patient’s cardiac, pulmonary, renal, and neurological status.
Develop a preoperative assessment of risk factors.
Review, prioritize, and order medications the patient is currently taking, as appropriate.
  - Use and understand the nursing notes and patient data.
Prescribe activity level, management of medications, pain management, follow up appointments, and obtain urgent contact information.

**Assessment of Basic Diagnostic Tests and X-Rays**
Recognize abnormalities in basic radiologic and laboratory tests and learn normal values and ranges.
Choose the optimal imaging technique.
  - Recognize:
    - pleural effusion on CXR
    - chest mass on CXR
    - pneumonitis on CXR
    - bowel gas patterns on flat plate abdomen
    - diaphragm abnormalities on CXR
    - spinal column fractures
    - cervical spine radiographs
  - Interpret basic EKG findings
  - Recognize ischemia & arrhythmia patterns on EKG.
Management of Fluid/Electrolyte and Acid Base Balance
Understand acid-base balance and the applications of body composition to fluid, electrolyte, and acid-base balance in health and disease.
Give fluid resuscitation, manage postoperative fluid requirements, and recognize and correctly manage acid-base disorders.
Make adjustments in fluid administration for comorbid conditions, e.g. renal or cardiac insufficiency, diabetes, hypovolemia.
   - Use CVP and urine flow rates for adjustments of fluid administration.
   - Perform a saphenous cut down.
   - Recognize and treat calcium and magnesium imbalance.

Fever, Microbiology, and Surgical Infection
Know the mediators of fever, differential diagnosis, evaluation and management of the febrile patient in order to initiate appropriate workup of fever and provide supportive treatment.
   - Initiate definitive treatment with appropriate antibiotics.
Be able to monitor antibiotic levels and recognize drug-related complications. Know the antibiotic of choice.
Know and apply the principles of prevention of nosocomial infections, sterile technique and universal precautions.
Order and interpret the appropriate imaging studies for localization of an infected focus.
   - Know and apply the principles of incision and drainage.
   - Know the proper use of prophylactic antibiotics.
Know the classification of wounds (clean, clean-contaminated, contaminated and infected).
Recognize the septic syndrome and initiate appropriate supportive treatment. Be familiar with the current literature concerning the causes and mediators of the sepsis syndrome and its pathophysiology.

Epidemiology and Public Health
   - Be knowledgeable in AIDS diagnosis and prevention of HIV infection.
Understand the epidemiology and treatment of sexually transmitted diseases and other communicable diseases.

Nutrition
   - Perform a metabolic assessment of the surgical patient.
   - Understand the metabolic implications of trauma and operation.
   - Know the indications for nutritional support of the surgical patient.
Know the methods of calculation of nutritional requirements in health and disease using the Harris-Benedict or similar formulae.
Know the composition of various enteral and parenteral formulas and adjust appropriately.
   - Calculate and order basic enteral or parenteral formulas.
   - Recognize complications of enteral and parenteral feedings.
   - Manage central IV lines.
   - Manage gastrostomy or jejunostomy feeding tubes.
Assess when a postoperative patient can be fed and assess adequacy of intake.
   Know and utilize comparative costs of nutritional support methods.

**Perioperative Preparation**
Complete, document, and assess appropriate workup, write preoperative orders, and obtain required consultation from other specialists.

**Surgical Skills**
   Learn surgical site positioning, preparation and draping. Perform as first assistant.
   Know how to obtain hemostasis of small vessels and exposure of the operative field.
Be familiar with common surgical instruments (scalpel, forceps, scissors, needle holders, hemostats, retractors, electrocautery) and suture materials and their proper uses.
Perform basic maneuvers, e.g. suture of skin, soft tissues, fascia; tie knots; obtain simple hemostasis.
   Learn basic techniques of dissection and handling of tissues.

   **Under supervision:**
   excise benign lesions of skin and subcutaneous tissues.
   perform lymph node biopsy.
   remove superficial foreign bodies.
   incise and drain an abscess.
   repair simple lacerations.
   repair umbilical and type I and II inguinal hernias.
   perform appendectomy.

**Sterile Technique**
   Understand indications for and utilize appropriate methods of routine and reverse isolation procedures.
   Maintain appropriate sterile technique in the ER, at the bedside, in the ICU, and in the office.

**Wound Management**
Differentiate between wound infection, hematoma, and seroma, and initiate therapy.
Perform extensive debridement with supervision.
Debride and pack wounds and apply dressings.
Recognize and differentiate between wound infection and necrotizing fasciitis, and detect crepitus.
Identify wound dehiscence and evisceration.
Know and apply the specific recommendations for tetanus immunization (active and passive).
Know the clinical manifestations of rabies in carrier and patient, and agents available to prevent development of the disease.
   Obtain proper wound specimen and perform and interpret Gram stain.
**Prioritize and Manage Complications**
Assess and manage complications or change in health status, such as:
- altered mental status.
- fever.
- hypotension.
- hypovolemia, oliguria.
- hypoxia.
- pain.
- vomiting, distention, nausea.
- bleeding at the bedside & coagulopathy.
- atelectasis, pneumonia, aspiration.
- fecal impaction, constipation
- chest pain,
- dyspnea
- pneumothorax
- congestive heart failure, pulmonary edema
- superficial phlebitis,
- pulmonary embolus
- urinary retention
- diabetic ketoacidosis or hyperosmolar coma
- peripheral ischemia or cyanosis
- seizures, alcohol or drug withdrawal

**ANESTHESIA ROTATION**

The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in preoperative care including preanaesthetic evaluation, anesthetic risk assessment, airway evaluation and immediate postoperative care.

At the completion of this rotation the PGY 1 resident should be knowledgeable in the following areas and be able to do:

**Basic laryngeal anatomy and physiology.**
Appropriate indications for general vs local anesthesia.
Appropriate preoperative evaluation including when to order a pre-operative chest x-ray, EKG, and laboratory tests based on the patient’s age, past medical history and social habits.
Write pre-anesthetic orders
Obtain oropharyngeal control of airway and provide Ambu ventilation

**Be able to perform:**
- orotracheal intubation
- nasotracheal intubation
laryngeal mask ventilation
jet ventilation
Interpret the anesthesia record
Position the patient properly for operative exposure, temperature control, and protection from pressure/ traction.
Be familiar with intraoperative monitoring.
Insert arterial and venous lines.

Know the dose range and complications (including pulmonary edema and Malignant hyperthermia) of the following agents:
  - barbiturates
  - local anesthetics
  - paralyzing agents
  - reversing agents
  - inhalant anesthetics
  - Know when and how to use epinephrine, hyaluronidase, in local anesthesia

As opportunity allows the PGY1 will participate in the following procedures under supervision:
  - administer a local block
  - administer general anesthesia
  - Understand and use conscious sedation

**CRITICAL CARE ROTATION (SICU)**

The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients in the intensive care setting.

At the completion of this rotation the PGY 1 resident should be knowledgeable in the following areas and be able to do:

**Critical Care and Management of Shock**
  - Differentiate types of shock (hemorrhagic, cardiogenic, septic, neurologic) and initiate appropriate therapy.
  - Insert central venous and arterial catheters and obtain hemodynamic data; interpret data and initiate therapy.
  - Recognize clinic presentation of a pneumothorax and insert chest tube
  - Understand and utilize basic principles of mechanical ventilation.
  - Recognize the indications for blood component therapy and initiate therapy.
  - Recognize a transfusion reaction and initiate management.
  - Institute measures to prevent upper GI bleeding in critically ill patients.

**Coagulation and Anticoagulation**
  - Choose the appropriate tests for diagnosis of a coagulopathy, and have a working knowledge of factor analysis.
Apply effective preventive measures for DVT and PE. 
Initiate and monitor therapeutic anticoagulation and its complications. 
Diagnose and manage acute deep venous thrombosis. 
Acutely manage a patient with a suspected acute pulmonary embolus, and provide a differential diagnosis.

**Applied Cardiac Physiology**
Recognize rhythm disturbances, myocardial ischemia on EKG. 
Assess, formulate a differential diagnosis and initiate therapy for hypotension. 
Know and apply appropriate treatment for supraventricular tachycardia. 
Treat congestive failure and acute pulmonary edema. 
Manage hypertension in a surgical patient. Understand multidrug therapy and the toxic and side effects of antihypertensive drugs.

**Applied Renal Physiology**
Know the pathophysiology of the development of acute renal failure; the differentiation of prerenal, renal, obstructive types of renal failure; and the general concepts of prevention and treatment of ARF. 
Recognize and treat simple electrolyte disturbances. 
Understand appropriate fluid replacement and balance.

**Applied Pulmonary Physiology**
Know the manifestations—clinical and by laboratory testing—of obstructive pulmonary disease and pulmonary insufficiency, and their surgical perioperative management. 
Recognize bronchoconstrictive disorders and their perioperative management.

**Applied Nutrition**
Learn to manage the nutritional needs of a critically ill patient. 
Placement of nasogastric tube and Dobhoff tube.

**Surgical Skills**
Develop surgical skills in CPR, CVC placement, arterial catheter placement, and chest tube placement. 
Perform first assistant in bedside bronchoscopy, pulmonary lavage, and tracheotomy. 
Obtain oropharyngeal control of airway, provide Ambu ventilation and perform Orotracheal intubation.

**EMERGENCY MEDICINE ROTATION**

The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients presenting to the emergency room, hospital consults or intensive care unit. The PGY1 resident should also gain a better appreciation of medical conditions often seen as co-morbidities in emergency patients including, diabetes mellitus, hypertension, stroke, congestive heart disease, respiratory distress and myocardial infarction.
At the completion of this rotation the PGY 1 resident should be knowledgeable in the following areas and be able to do:

Conduct primary assessment and take appropriate steps to stabilize and treat patients with trauma (penetrating and blunt), respiratory distress, congestive heart failure, metabolic imbalances, myocardial infarction, and chronic pain.

Establish the acuity level of patients in the ER, establish priorities and define the tasks necessary to manage the patients successfully.

Monitor, observe, manage, and maintain the stability of one or more patients who are at different stages in their work-ups including fundamental lab tests and radiological studies.

Recognize and initiate treatment for an acute anaphylactic reaction.

Collaborate with physicians and other professionals to evaluate and treat patients, arrange appropriate placement and transfer if necessary, formulate a follow-up plan, and communicate effectively with patients, family, and involved health care members.

Closure of simple and complex lacerations.

Develop some familiarity with disaster management.

**NEUROSURGERY ROTATION**

The main goal of this rotation is to provide the PGY1 resident an organized experience to enable him/her to acquire the basic knowledge and skills in the evaluation and management of patients presenting with neurosurgical complaints. The resident should gain an appreciation for the collaborative efforts between the ORL and NES.

At the completion of this rotation the PGY 1 resident should be knowledgeable in the following areas and be able to do:

Review basic cranial anatomy including cranial nerve origin and function.
Perform neurosurgical patient evaluation, assessment and management.
Learn evaluation and treatment of neurological trauma, critical care and emergencies.
The indications for and basic interpretation of diagnostic tests and X-rays including basic head CT and MRI imaging studies.
Basic neurosurgical skills, technique, and wound management including simple Craniotomy and craniotomy closure.
Recognition, diagnosis, and basic management of CSF leaks.
Insertion and management of a lumbar drain.
Management of common neurosurgical complications.
Differentiate between stroke, TIA, and non-cerebrovascular events causing neurological symptoms and know the diagnostic techniques.
Participate in at least 5 major procedures.
ENT ROTATION: General

The main goal of the PGY-1 Otolaryngology rotation is to provide the resident exposure to common adult and pediatric practices in otolaryngology and the opportunity to participate in minor surgical techniques. In the process, they shall be able to acquire a rudimentary understanding and skills necessary for the evaluation and management of patients with diseases of the head and neck. Rotation in Otolaryngology during the PGY-1 year includes three months of dedicated observation/education/practice in the academic arena. This includes time spent both at the university and children’s hospitals. Focused education in pathology and neuroradiology will also be achieved.

Dedicated one month rotations include:

<table>
<thead>
<tr>
<th>Rotation</th>
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<tbody>
<tr>
<td>Pediatric Otolaryngology</td>
<td>ACH</td>
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<tr>
<td>Adult Otolaryngology</td>
<td>UAMSMC</td>
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</table>

At the completion of this PGY-1 rotation, the resident shall have:

An understanding of basic anatomy of the head and neck with focused attention on the ear, nose, oral cavity, pharynx, larynx and neck. This will require self directed learning augmented with education in neuroradiology and time on clinic service. Rudimentary understanding of the basic physiology of the head and neck.

Perform:
- Basic head and neck examinations
- Flexible nasopharyngoscopy
- Flexible laryngoscopy
- Microscopic examination of the ear
- Anterior nasal packing for epistaxis
- Repair of simple facial lacerations
- Obtained a history and physical for basic ENT-related problems
- Demonstrated surgical skills in basic otolaryngology procedures including:
  - Tonsillectomy/Adenoidectomy
  - Myringotomy and placement of pressure equalization tubes
  - Wound repair
  - Endoscopic airway evaluation
- Been involved in management of the acute airway (adult/pediatric)
- Observed anterior nasal packing for epistaxis
- Performed basic perioperative management of ENT patients

Participate in “buddy call” where they accompany a senior resident during call duty and observe an and/or perform call responsibilities where many of the above educational points are achieved.

Observe senior residents and faculty perform complex otolaryngology procedures with some participation with direct guidance.
Observe and participate in otolaryngology patient clinic evaluations, diagnosis and management decisions.

**Orientation:**
During the months of May, June & July, The PGY 1 residents are required to attend orientation lectures which provide basic knowledge of head and neck cancer, laryngology, speech, pediatric otolaryngology, allergy and sinus, Risk Management, IRB, ER / On Call, Facial Trauma, Airway, Thyroid, Ear Disease and Physician Billing Overview

The PGY-1 resident will participate in daily rounds with the other residents on that particular service and will be under the supervision of the chief resident and the attending present at that institution. The PGY-1 resident is required to attend all didactic lectures and conferences within the department while on this rotation.

PGY-1 residents also receive a series of orientation lectures by our faculty specialists and related fields to prepare them at the end of their pgy-1 year for the years ahead.
# OTOLARYNGOLOGY GENERAL COMPETENCIES
## PART 1

<table>
<thead>
<tr>
<th>Competency</th>
<th>Required Skill(s)</th>
<th>Specific Objectives</th>
<th>Teaching Method</th>
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<tr>
<td><strong>1.</strong> Demonstrates kindness &amp; respectfulness</td>
<td>1. Residents develop and recognize the need for compassionate &amp; understanding behavior</td>
<td>Direct faculty supervision of outpatient and inpatient clinical encounters, including all procedures</td>
<td>Didactics (Weekly: Sept. - May) Tumor Board (Weekly: Sept. - May)</td>
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<td><strong>PATIENT CARE</strong></td>
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<td>3. Demonstrates &amp; supports clinical &amp; surgical procedures</td>
<td>3. Residents exhibit procedural clinical and surgical competency</td>
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<td><strong>MEDICAL KNOWLEDGE</strong></td>
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<tr>
<td>2. Knowledge and application of basic science</td>
<td>2. Residents apply appropriate basic science to clinical and surgical skills</td>
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<td>3. Didactics (Weekly: Sept. - May) 4. Grand Rounds (Monthly)</td>
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<tr>
<td>7. Temporal Bone Lab (2x per month: Sept.-May)</td>
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<td>8. Home Study Course</td>
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<td>9. AAO/HNS Meeting (Twice in Residency)</td>
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<tr>
<td>10. Inservice Exam Preparation</td>
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<td>11. PGY 2’s July rotation is orientation Conference Education (every 2 years)</td>
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<td>1. FESS 2. Pathology 3. Plating 4. Temporal Bone</td>
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<td><strong>PRACTICE BASED LEARNING AND</strong></td>
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<tr>
<th>IMPROVEMENT</th>
<th>4). Facilitate learning to others</th>
<th>during monthly rotations.</th>
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| 8). M & M | 9). AAO/HNS Meeting (Twice in Residency) | 10). Home Study Course |

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<td>1. Respectful</td>
<td>Residents develop and are proficient in</td>
<td>1). Observation of faculty professionalism</td>
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<td>2. Ethically sound to practice</td>
<td>non-judgemental and respectful</td>
<td>2). Didactics</td>
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<tr>
<td>3. Skilled and sensitive to</td>
<td>attitudes to patients.</td>
<td>3). Tumor Board</td>
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<td>4. M &amp; M</td>
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| PROFESSIONALISM | deal with cultural, age, gender and disability issues | once during residency |

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<td>Residents become proficient in developing rapport with patients.</td>
<td>1). Residents observe faculty</td>
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<td>2. Become proficient in listening skills.</td>
<td>2). Residents demonstrate the ability to take a detailed history of the patients.</td>
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<td>3. Residents become proficient in communicating clear information regarding treatment the patient will need.</td>
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| INTERPERSONAL AND COMMUNICATION SKILLS | deal with cultural, age, gender and disability issues | once during residency |

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<th>SYSTEMS BASED PRACTICE</th>
<th>comprehend of practice and delivery systems</th>
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# OTOLARYNGOLOGY GENERAL COMPETENCIES

## PART 2

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<td>1) Monthly Faculty Meeting</td>
<td>1) Semi-Annual Review with Program Director</td>
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<td>2) Faculty Evaluate Res.: Semi &amp; Annual</td>
<td>2) Annual Faculty Retreats</td>
<td>2) Annual Meeting with Education Committee</td>
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<td>3) Residents Evaluate Faculty: Annual</td>
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<td>4) Peer Review: Annual</td>
<td>4) RRAD Evaluation with awards: Annual</td>
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<td>5) Grand Rounds Evaluation: Annual</td>
<td>6) Peer Review: Annual</td>
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## 2014-2015 PGY 1 “INTERN” ROTATION SCHEDULE

### DEPARTMENT OF OTOLARYNGOLOGY - HEAD AND NECK SURGERY

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## 2014-2015 Otolaryngology Resident Rotation Schedule

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CALL SCHEDULE

The senior resident at the VA is responsible for filling out the monthly call schedule which is to be turned in to the residency coordinator one month in advance to allow for typing and distribution.

All calls from the ER will be handled by the residents at each institution during usual work hours, i.e. 7:00 a.m. - 5:00 p.m. during the week. After that, calls will be taken by the first call resident. The first call resident will be responsible for consults or admissions unless previous arrangements were made for the patient to be admitted by a primary service. If any question about diagnosis or treatment arises, the second call resident and/or staff should be called. If any political problems arise in the ER, immediately contact the staff on call. All direct transfers from other hospitals are to be directed through the transfer team at 688-9553 or the ICU/Intermediated Bed Team at 688-2134. The transfer team should usually be the one to channel any patients through the ER to rule out other trauma prior to being admitted to the ward. The staff on call or the staff responsible for the service to which a patient is admitted must be notified about any admissions. Staff must be consulted about any emergency surgical procedure and should be notified of any death or potentially serious complication.

For all non-emergent hospital to hospital transfers at UAMSMC, we have developed and trained a staff member to handle any and all of these transfers. When you get a call from an outside facility about transferring a patient to UAMS, you are encouraged, if appropriate to say: “we will be happy to care for the patient clinically, but we will need to have our transfer team call you to make the necessary arrangements.” This process was approved by the Clinical Chairs and Dean late 2003 and implementation began in 2006. This includes all hospital to hospital transfers of patients who are already admitted inpatients as well as emergent patients in another facility. This will also include bone marrow transplant patients. All of these calls should be directed to a single beeper number, which is: 688-9553.

Once the call has been placed to the transfer team they will contact the transferring facility and request the necessary information to allow us to transfer the patient. If the team questions whether the transfer is appropriate, they will contact the attending physician and, if there is agreement, the team will inform the facility that the transfer request is denied, and the UAMS physician will likewise inform the referring physician. In some cases, transfer may depend on the transferring institution’s commitment to accept the patient back for ongoing or chronic care as a condition for transfer acceptance. In other cases, the transfer will be deemed appropriate and, when an appropriate bed is available, the patient will be officially accepted for treatment. Admission denials may be appealed through the UAMS Medical Director. This policy has been made necessary by the frequency of inappropriate transfers and by our severely restricted current bed resources.

The PGY1 resident during their designated ENT months will take “buddy call.”
# OTOLARYNGOLOGY/FACIAL TRAUMA

## CALL SCHEDULE - July 2012

This schedule covers facial trauma only. Contact Dr. Yuen for plastic call.

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<td>Gluth 412-9758 Lawson 688-2165 Gluth 412-9758</td>
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<td>Tues 24</td>
<td>Marino 405-1952</td>
<td>Bockemann 688-6664</td>
<td>Gluth 412-9758 Marino 405-1952 Gluth 412-9758</td>
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<td>Thurs 26</td>
<td>Metrailler 688-6173</td>
<td>Bockemann 688-6664</td>
<td>Gluth 412-9758 Metrailler 688-6173 Gluth 412-9758</td>
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<td>Fri 27</td>
<td>Cox 688-2146</td>
<td>Bockemann 688-6664</td>
<td>Moreno 412-1903 Cox 688-2146 Moreno 412-1903</td>
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<tr>
<td>Sat 28</td>
<td>Giene 405-9582</td>
<td>Friedman 688-6665</td>
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<td>Mon 30</td>
<td>Rutledge 688-6668</td>
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<td>Moreno 412-1903 Rutledge 688-6668 Moreno 412-1903</td>
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<td>Tues 31</td>
<td>Hobbs 688-6669</td>
<td>Friedman 688-6665</td>
<td>Moreno 412-1903 Hobbs 688-6669 Moreno 412-1903</td>
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</tbody>
</table>

*First and second call responsibility is to the following hospitals and must be taken at home by telephone or pager. Veterans Admin Hospital, ACH, and UAMS. Monday’s first call starts at 7:00am and ends at 10:00am. During normal working hours (7am-5:00pm) contact the resident assigned to the hospital whose emergency service you need. Weekend call starts 7am Saturday and ends at 11am on Monday. If physician on first call cannot be reached after a reasonable attempt, call the physician on second call. Always try the VAS or UAMS operator. If it should occur that the second physician cannot be reached, call the physician through the appropriate operator or any available resident.*
EDUCATIONAL OVERVIEW

General – Department Meetings
Residents develop knowledge and judgmental skills through a combination of didactic teaching in conferences and active participation in conferences and seminars, ward rounds, self-directed reading, audio-visual instruction and attendance at local, regional, and national meetings. Attendance at all monthly teaching conferences is mandatory and attendance is documented, as stipulated by the Residency Review Committee for Otolaryngology. Residents are expected to be at all conferences on time as it is embarrassing and rude to have speakers wait for you. Residents are expected to be respectful of all speakers and their presentations.

**Required Monthly Conferences**

<table>
<thead>
<tr>
<th>Conference</th>
<th>Day</th>
<th>Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>M&amp;M / QI Conference</td>
<td>1st Tuesday of the month</td>
<td>7:15 am</td>
<td>UAMS: JTS – Rm. 640</td>
</tr>
<tr>
<td></td>
<td>3rd Tuesday of the month</td>
<td>7:15 am</td>
<td>ACH: G4058-1L</td>
</tr>
<tr>
<td>Didactic lectures</td>
<td>1st &amp; 4th Tuesdays</td>
<td>6:30 am</td>
<td>UAMS: Stephen’s Building</td>
</tr>
<tr>
<td>September thru May</td>
<td>2nd Tuesday</td>
<td></td>
<td>Oto Admin. Conf. Rm., Rm. 640, 6th floor</td>
</tr>
<tr>
<td></td>
<td>3rd Tuesday</td>
<td></td>
<td>ACH: Sturgis Building, G4058-1L</td>
</tr>
<tr>
<td>H&amp;N Tumor Conf.</td>
<td>Mondays</td>
<td>5:00 pm</td>
<td>UAMS: JTS Rm. 640</td>
</tr>
<tr>
<td>Grand Rounds</td>
<td>4th Tuesday of the month</td>
<td>7:15 am</td>
<td>UAMS: JTS – Rm. 640</td>
</tr>
<tr>
<td>Journal Club</td>
<td>3rd Thursday of the month</td>
<td>7:00 pm</td>
<td>Home of hosting faculty</td>
</tr>
<tr>
<td>Otology Surgical Skills Lab</td>
<td>1st Thursday of the month</td>
<td>7:00 pm</td>
<td>UAMS: JTS - 6th Floor</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Otology Surgical Skills Lab</td>
</tr>
<tr>
<td>Basic Science Reviews</td>
<td>Every Monday July – 1st</td>
<td>7:00 pm</td>
<td>Home of hosting resident</td>
</tr>
<tr>
<td></td>
<td>Monday in September</td>
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</table>

**Otology Surgical Skills Lab**
Temporal bone lab experience will consist of formal sessions and an independent drilling regime as instructed and supervised by John Dornhoffer, M.D. that are held on the 1st Thursday of each month.

**Required Yearly Meetings**

- Board Review Sessions
- Resident Research and Alumni Day

**Every Other Year**
- FESS Course
- Temporal Bone Course
- Allergy Course

**Intermittent**
- Pathology Review (July of each year)
- Other courses as determined by program director
- Pathology Course
- Plating Course
- Laryngeal Framework Surgery Course
General Information

Family Practice Resident Rotation with Otolaryngology
During this two week rotation the family practice resident spends most of their time in the UAMSMC ENT Outpatient Clinics. Only one family practice resident is allowed to rotate at a time. They most often will shadow the faculty attending in private clinics and occasionally will shadow the otolaryngology resident in “Resident’s Clinic” (faculty supervised) in order to observe “common” Otolaryngic problems they may encounter in the private practice setting. They observe how the faculty and resident approach the patient evaluation and management of common ENT disorders. The family practice resident is not expected to see patients independently, although at times, and depending on their level of training and expertise, they may be allowed to perform a general history on the ENT patient and subsequently present to the attending or otolaryngology resident. The family practice resident receives instruction through discussion of the specific disorder and ENT physical exam techniques and findings are demonstrated. Treatment options are discussed as well as decision making algorithms for surgery. On occasion the family practice resident might observe selected surgical cases in the OR.

One of the goals of the rotation is for the family practice resident to glean appropriate workup and referral criteria which enhances their ability to interact with the otolaryngologist from their primary care practice.

The experience not only benefits the family medicine resident but it also provides our residents with an opportunity practice and polish their “educator” and communication skills. Special effort is made to assure that the otolaryngology resident is the priority and to assure that this “outside resident” does not detract from the otolaryngology resident’s learning opportunity. It is interesting that the family practice resident often brings a different perspective to patient evaluation, often a more holistic one, to this experience which helps our residents and faculty to see the patient in an alternative light as well.

Medical Students
Approximately four medical students rotate on our service every two weeks. They are given schedules and hospital assignments in advance of their rotation. The resident in charge of the students at each hospital should review this schedule with them on the first day of the clerkship. Please fill out the student evaluation forms and return them to the medical student coordinator. New goals and guidelines will be provided to each student rotating through our service, and the residents should make every effort to assist these students in achieving these goals. At least one medical student is on service at each hospital; evaluations are to be filled out by the chief resident of the service, and countersigned by the chief of the service at each hospital.

Senior students from other institutions who rotate to UAMS are able to spend a full month on service with the Department of Otolaryngology. The student “shadows” an Otolaryngology resident each day. The resident should offer the student guidance in clinics, operating rooms, on rounds, and supervise them as requested.
Otolaryngology Library
The Department of Otolaryngology maintains a library of major otolaryngology journals, textbooks, and instructional videotapes. All residents are encouraged to use the library as a quiet study room. Books may be checked out through the librarian. Next door to the library is a computer station dedicated to resident use. All residents must purchase a basic ENT textbook such as Bailey’s Head and Neck Surgery – Otolaryngology or Cummings set. Residents should purchase other texts of their interest as they advance in the program.

<table>
<thead>
<tr>
<th>STIPENDS and BENEFITS</th>
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<tbody>
<tr>
<td>PGY 1 $48,024</td>
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<tr>
<td>PGY 2 $49,007</td>
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<tr>
<td>PGY 3 $50,623</td>
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<tr>
<td>PGY 4 $51,969</td>
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<tr>
<td>PGY 5 $53,854</td>
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Book / Journal Allotment
Residents in their PGY1 year will be allowed $500.00 and residents in their PGY2-5 years will be allowed a $1000.00 book fund each academic year. **UAMS policy requires that all purchases using your book fund must be go through the purchasing officer in our department, Janet Williams.**

The **AAO/HNS dues and 2 lab coats** are covered by the department separate from your $1000.00 bookfund.

Health Services and Hospitalization
Health services and hospitalization are provided to all members of the staff. Coverage for spouses and children may be purchased by the individual housestaff member. No salary deductions are made for time lost due to illness. According to the American Board of Otolaryngology an excess of six weeks (beyond the allowed three weeks of vacation) of time lost in this manner, must be made up before the College of Medicine can issue a certificate indicating satisfactory completion of internship or residency requirement.

Professional Liability Insurance
Each housestaff physician is provided professional liability insurance when on official duty during resident training. Such insurance is specifically **NOT** provided for moonlighting. Liability insurance for moonlighting must be purchased by the resident.

Parking
Parking decals are available from the Housestaff Office at no cost to you. With this decal on your car, you can park on the top level of the parking deck after 10:30 p.m. to answer emergency calls. At other times, you must park on the lower levels of the deck.
EVALUATIONS

RESIDENT EVALUATION OF FACULTY (Annually)
Residents are allowed to evaluate faculty annually through the New Innovations Residency Management System. Score summaries and typed comments are given to the residency director, the chairman, and each staff member.

RESIDENT EVALUATION BY FACULTY

ROTATIONAL REVIEW OF RESIDENT (Short Evaluation Form) (began June 2007)
Residents will be evaluated rotationally by otolaryngology faculty at UAMS (University of Arkansas for Medical Sciences), ACH (Arkansas Children’s Hospital), the VA (Veterans Administration) and by the director of Otology through the New Innovations Residency Management System. This review assesses residents rotationally, both subjectively and objectively, as they progress through the training program. Faculty members supervise residents on all levels of training giving faculty members the ability to access, identify and evaluate each resident according to their PGY level. In addition, the Program Definition, Scope, General Program Requirements, Goals and Objectives (including the general competencies) as stated in the Resident Job Description of this manual are also used by the faculty in evaluating the Otolaryngology resident. Residents must pass certain cognitive and clinical milestones in order to progress to the next level of training. Advancement to the subsequent year of training with greater involvement and independence in specific patient care activities requires satisfactory ratings on these evaluations per the protocol in the training program. Deficiencies in acquisition of knowledge and skills must be identified early so that appropriate corrective measures may be instituted. Such review is required by the Residency Review Committee for Otolaryngology.

Rotational evaluations will be compiled and provided to the Program Director during the semi-annual review of the otolaryngology resident.

RESIDENT SELF EVALUATION (Annually)
The resident reviews him/herself from the perspective of the patient and self knowledge and competency through the New Innovations Residency Management System. The program coordinator then uses the system to compile score summaries and typed comments to be given to the residency director, the chairman.

PEER EVALUATION (Annually)
Residents evaluate each other on patient care, medical knowledge, professionalism, and communication skills through the New Innovations Residency Management System. The program coordinator then uses the system to compile score summaries and typed comments to be given to the residency director, the chairman.

NURSES EVALUATION OF RESIDENT (Annually)
Nurses evaluate residents on patient care, medical knowledge, professionalism, and communication skills through the New Innovations Residency Management System. The program coordinator then uses the system to compile score summaries and typed comments to be given to the residency director, the chairman.
ADMINISTRATIVE STAFF EVALUATION OF RESIDENT (Annually)
Administrative staff reviews residents on professionalism, and communication skills through the New Innovations Residency Management System. The program coordinator then uses the system to compile score summaries and typed comments to be given to the residency director, the chairman.

PATIENT EVALUATION OF RESIDENT
Patients are asked to review the resident regarding overall quality of care, physician competency, courtesy, empathy/interest, listening skills, provision of information, etc. This information is gathered in the ACRC clinic and tallied by the Office of Educational Development.

RESIDENT EVALUATION OF PROGRAM (Annually)
Residents anonymously submit program reviews through the New Innovations Residency Management System. The program coordinator then uses the system to compile score summaries and typed comments to be given to the residency director, the chairman, and each staff member.

FACULTY EVALUATION OF PROGRAM (Annually)
Faculty submits program reviews through the New Innovations Residency Management System. The program coordinator then uses the system to compile score summaries and typed comments to be given to the residency director, associate program director, the chairman, and each staff member.

SUMMATIVE WRITTEN EVALUATION
Formal written evaluations of each resident are prepared at the end of their five year tenure by the residency director. All evaluations become part of the resident’s permanent file.
Subject: Addressing Concerns in a Confidential and Protected Manner

Purpose: To establish a forum and procedure by which an individual resident or groups of residents can address concerns in a confidential and protected manner in the Department of Otolaryngology – Head and Neck Surgery Residency Programs.

Date Developed: December 2004

Updated: October 2011

Responsible Party: Chairman / Program Director

Compliments: UAMS, GME Policy on Addressing Concerns in a Confidential and Protective Manner, Number 1.400: ACGME Institutional II.F.1; Common II.A.4.h.

Definitions
Resident Council: the oversight body of the University of Arkansas for Medical Sciences College of Medicine Resident Organization. It is a standing subcommittee of the GMEC and has equal authority with the other subcommittees. It is composed of peer-elected residents, appointed chief residents and other residents who represent special groups (e.g. AAMC Organization of Resident Representatives, AMA Resident Section).

Policy
Each residency program must have a written procedure by which individual residents can raise concerns in a confidential and protected manner. These procedures must be communicated to all residents. The procedures shall include a designated contact person within (e.g. Chief Resident, Program Director, Departmental Chairperson or designated faculty member) or outside the program with whom the resident can discuss issues of concern.

Procedure
If the issue is of such a nature that it cannot be discussed at the program level or the resident desires additional discussion, the resident should follow the following procedure:
1. The resident contacts either the Associate Dean for GME or a member of the Resident
2. If the resident wishes assistance from the Resident Council, the following steps should be followed:

   a). The resident should contact at least two members of the Resident Council to schedule a meeting to discuss the problem confidentially.

   b). The Resident Council members will meet with the resident and offer advice on how to resolve or handle the problem and if further steps are necessary. Based on the discussion and advice at this meeting, the resident may resolve the problem, and no further action is necessary.

   c). If the resident's problem cannot be resolved or is of such a nature that further information is needed, the Resident Council members should discuss the problem with the Associate Dean for GME or the GMEC Chair.

3. The procedure for resolution will vary depending on the type of issue.

4. Discussions and recommendations by the Resident Council and/or the GMEC are confidential to the extent authorized by law and handled in a manner to protect the resident.

Where specific policies are not stated, GME policy is followed. Please see the University of Arkansas for Medical Sciences, Graduate Medical Education Resident Handbook, http://www.uams.edu/gme/policies.htm.
Disciplinary Actions

All of the disciplinary actions listed below are done in compliance with UAMS COM GME policy on disciplinary actions.

Remediation Status - is defined as the initial trial period in which a resident is permitted to redeem academic performance or behavioral conduct (before being placed on probation) such as but not limited to:

- Failure to attend and perform satisfactorily at all scheduled conferences, morning rounds, the outpatient clinic and the operating room.
- Failure for the PGY 3, 4, and 5 to make 50% or better within their respective year and PGY2 to make 30% or better on the annual otolaryngology in-service examination.
- Repeated reports of "below expectations" on the resident evaluation form.

When a resident is placed on remediation, the Program Director will provide specific remedial steps to correct the deficiency or problem and will indicate a specific amount of time to make the correction.
**Probation** - is defined as the trial period in which a resident is permitted to redeem academic performance or behavioral conduct for any one or more of the following:

- Failure to correct the deficiency or problem mentioned during the time allowed when previously placed on academic warning status.
- Failure to comply with the policies and procedures of the Training Program, the GME Committee, UAMS Medical Center or the participating institutions.
- Misconduct that infringes on the principles and guidelines set forth by this training program.
- Documented and recurrent failure to complete medical records in a timely and appropriate manner.
- When reasonably documented professional misconduct or ethical charges are brought against the resident which bear on his/her fitness to participate in the training program.

When a resident is placed on probation, the Program Director shall provide specific remedial steps to the resident in a written statement within a week of the notification. The statement will specify the period of time in which the resident must correct a deficiency or problem, the specific remedial steps and the consequences of non-compliance with the remediation. Based upon the resident's compliance with remedial steps, the resident may be:

- Continued on probation
- Removed from probation
- Suspended, or
- Dismissed from the residency program

**Suspension** - is defined as a period of time in which a resident is not allowed to take part in all or some of the activities of the training program. A resident may be suspended from clinical or other activities of the training program for reasons including, but not limited to, any of the following:

- Failure to meet the requirements of probation.
- Failure to meet the performance standards of the training program
- Failure to comply with the policies and procedures of the Training Program, the GME Committee, the UAMS Medical Center, or the participating institutions.
- Misconduct that infringes on the principles and guidelines set forth by this training program
- Documented and recurrent failure to complete medical records in a timely and appropriate manner defined as above
- Misconduct or failure to meet ethical standards which bear on his/her fitness to participate in the training program
- When reasonably documented legal charges have been brought against a resident which bear on his/her fitness to participate in the training program
- If a resident is deemed an immediate danger to patients, himself or herself or to others
- If a resident fails to comply with the medical licensure laws of the State of Arkansas

If suspension is deemed necessary, the Program Director notifies the resident through a written statement, with a copy to the Associate Dean for GME, to include:

- Reasons for the action
- Specific and appropriate measures to assure satisfactory resolution of the problem(s)
Activities of the program in which the resident may and may not participate
The date the suspension becomes effective
Determination of leave with or without pay
Consequences of non-compliance with the terms of suspension
Whether the resident is required to spend additional time in training to compensate for the period of suspension and be eligible for certification for a full training year

During the suspension, the resident will be placed on leave, with or without pay as appropriate depending on the circumstances. At any time during or after the suspension, the resident may be reinstated with no qualifications, reinstated on probation, continued on suspension or dismissed from the program.

**Dismissal** - is the condition in which a resident is directed to leave the training program, with no award of credit for the current training year. Dismissal from the training program may occur for reasons including, but not limited to, any of the following:

- Failure to meet the performance standards of the training program
- Failure to comply with the policies and procedures of the training program, the GME Committee, the UAMS Medical Center, or the participating institutions
- Illegal conduct
- Unethical conduct
- Performance and behavior which compromise the welfare of patients, self, or others
- Failure to comply with the medical licensure laws of the State of Arkansas
- Inability of the resident to pass the requisite examinations for licensure to practice medicine in the United States

1. If dismissal is planned, the Program Director shall contact the Associate Dean for Graduate Medical Education and provide written documentation, which led to the proposed action.
2. Immediate dismissal can occur at any time without prior notification in instances of gross misconduct (e.g., theft of money or property; physical violence directed at an employee, visitor or patient; use of alcohol/drugs while on duty; other illegal conduct).
3. When dismissal is being considered because of performance or conduct, the Program Director shall notify the resident in writing of the basis of the action, the proposed action, the requirements for the resident and timeframe for satisfactory resolution of the problem(s).
4. In the event the situation is not improved within the timeframe, the resident will be dismissed.

A resident involved in the disciplinary actions of probation, suspension and dismissal has the right to appeal according to the GME Committee policy Adjudication of Resident Grievances. Please see the manual entitled General Manual for Housestaff, University of Arkansas for Medical Sciences, College of Medicine, for a full discussion of these procedures. These are the guidelines that will be used by the department.

Where specific policies are not stated, GME policy is followed. Please see the University of Arkansas for Medical Sciences, Graduate Medical Education Resident Handbook, [http://www.uams.edu/gme/policies.htm](http://www.uams.edu/gme/policies.htm).
Subject: Resident Duty Hour Policy

Purpose: To establish standards for duty hours in the learning and working environment for Otolaryngology residents.

Date Developed: July 2004

Updated: October 2011

Responsible Party: Chairman / Program Director

Compliments: UAMS, GME Policy on Duty Hours and Work Environment, Number: 3.200; ACGME Requirements: Institutional II.D.i., II.F; Common VI; RRC Procedures for Granting Duty Hours Exceptions

Purpose
To establish guidelines of travel and leave for the professional development of the otolaryngology resident while maintaining the financial viability of the department.

Definitions
Duty hours are defined as all clinical and academic activities related to the residency program, ie, patient care (both inpatient and outpatient), administrative duties related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities such as conferences. Duty hours do not include reading and preparation time spent away from the duty site. www.acgme.org/DutyHours/dutyHoursCommonPR.asp

At-home call (pager call) defined as call taken from outside the assigned institution.

Policy
The Department of Otolaryngology is committed to providing the otolaryngology resident with a sound academic and clinical education environment, placing our emphasis on patient safety and resident well-being. By educating the otolaryngology faculty and residents of the collective balance/responsibility for the safety and welfare of patients and to ensure assignment of appropriate duty hours we insure that our otolaryngology residents avoid undo stress and fatigue. Excessive reliance on the otolaryngology resident to fulfill service obligations will not be
accepted. Priority is placed on didactic and clinical education for the allotment of the residents’ time and energies. Duty hours and on call schedules will focus on the needs of the patient, continuity of care, and the educational needs of the resident.

If a resident feels that fatigue is interfering with his/her ability to safely perform his/her duties, that resident should contact the Program Director immediately. Accommodations will be made to assure patient safety and continuity of care. If the program director is not available, the Department's Chairperson should be contacted in his/her stead.

Resident Duty Hour Requirements

1) **Maximum Hours of work per week**
   (a) Duty hours must be limited to 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities and all moonlighting.

2) **Mandatory Time Free of Duty**
   (a) Residents must be scheduled for a minimum of one day free of duty every week (when averaged over four weeks). At-home call cannot be assigned on these free days.

3) **Maximum Duty Period Length**
   (a) Duty periods of PGY-1 residents must not exceed 16 hours in duration.
   (b) Duty periods of PGY-2 residents and above may be scheduled to a maximum of 24 hours of continuous duty in the hospital.
      1. It is essential for patient safety and resident education that effective transitions in care occur. Residents may be allowed to remain on-site in order to accomplish these tasks; however, this period of time must be no longer than an additional four hours.
      2. Residents must not be assigned additional clinical responsibilities after 24 hours of continuous in-house duty.
      3. In unusual circumstances, residents, on their own initiative, may remain beyond their scheduled period of duty to continue to provide care to a single patient. Justifications for such extensions of duty are limited to reasons of required continuity for a severely ill or unstable patient, academic importance of the events transpiring, or humanistic attention to the needs of a patient or family.
         a. Under those circumstances the resident must:
            i. Appropriately hand over the care of all other patients to the team responsible for their continuing care; and,
            ii. Document the reasons for remaining to care for the patient in question on the 24+ report and submit the report in every circumstance to the program director
         b. The program director must review each submission of additional service, and track both individual resident and program-wide episodes of additional duty.

4) **Minimum Time Off between Scheduled Duty Periods**
   a) PGY-1 residents should have 10 hours, and must have eight hours, free of duty between scheduled duty periods.
   b) Intermediate-level residents, PGY-2 and PGY-3 residents, should have 10 hours free of duty, and must have eight hours between scheduled duty periods. They must have at least 14 hours free of duty after 24 hours of in-house duty.
c) Residents in the final years, PGY-4 and PGY-5 residents, of education must be prepared to enter the unsupervised practice of medicine and care for patients over irregular or extended periods.

5) **At-Home Call**
   a) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.
      1) At-home call must not be so frequent or taxing as to preclude rest of reasonable personal time for each resident
   b) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new “off-duty period”.

Falsification of duty hour’s data or pressure to cause the falsification of such data is considered egregious behavior for residents and can result in disciplinary action to include dismissal. Faculty members are governed by the Faculty Group Practice and University policies and procedures and terms of the Faculty Group Practice agreement. Residents must notify the Program Director of requests or pressure to work in excess of duty hours authorized by this policy.

**Monitoring of PGY 2 – PGY 5 Otolaryngology duty hours will take place twice in each academic year.** The otolaryngology resident will be notified by the program coordinator one month prior to the initiation of both of these events. All Otolaryngology residents are required to participate in the monitoring of their duty hours.

**All Otolaryngology PGY 1’s are required to log their duty hours on a weekly basis.**
Memorandum of Understanding
between the
UAMSMC Department of Otolaryngology – Head and Neck Surgery
and
________________, M.D.
(resident name)

1. I understand that the policy of the UAMSMC Department of Otolaryngology Head and Neck Surgery is that residents shall not exceed ACGME duty hour requirements. The UAMSMC Department of Otolaryngology Head and Neck Surgery shall not make assignments that knowingly violate ACGME duty hour requirements for its PGY 2-5 residents. PGY1 residents are asked to assist with monitoring duty hour work assignment hours while on non-otolaryngology head and neck surgery rotations.

2. As a PGY1 resident I understand that I am required to submit a weekly report to the Department of Otolaryngology Head and Neck Surgery (currently using New Innovations) during my PGY1 academic year. I agree to comply with this requirement. I understand that failure to comply with this requirement may result in corrective and/or disciplinary action. _______ (Initials)

3. As a PGY2-5 resident I understand that they I am required to submit a weekly report (currently using New Innovations) during the months of August and April of each year to the Department of Otolaryngology Head and Neck Surgery. I agree to comply with this requirement. I understand that failure to comply with this requirement may result in corrective and/or disciplinary action. _______ (Initials)

4. I understand that if at any time I am in danger of exceeding any of the ACGME duty hour limits it is my duty to immediately notify the Otolaryngology Head and Neck Surgery Residency Program Director or his designee. I understand that failure to do so will result in disciplinary and corrective action.

5. With this Memorandum of Understanding, I have received a copy of the ACGME Duty Hour Standards.

____________________________  ________________
Resident Signature                  Date
Subject: Evaluation and Promotion

Purpose: To define guidelines and procedures to the Otolaryngology Resident for evaluation and promotion

Date Developed: November 2006

Updated: October 2011

Responsible Party: Chairman / Program Director

Compliments: UAMS, GME Policy on Evaluation and Promotion, Number 1.300: ACMGE Institutional II.D.4.d & III.B.6 & 7; Common V

**Purpose**
To describe the policy and procedures pertaining to evaluation and promotion of the Otolaryngology – Head and Neck Surgery residents.

In compliance with the UAMS COM GME Committee policy on Evaluation and Promotion, the following guidelines apply:

**Reappointment**

Educational appointments to the Otolaryngology Residency program are for a term not exceeding one year. The resident agreement of appointment, which outlines the general responsibilities for the College of Medicine and for the resident, is signed at the beginning of each term of appointment. Renewal of the resident agreement of appointment for an additional term of education is the decision of the Program Director and the Department Chair. Promotion to the next level of training is dependent upon the resident/fellow performing at an acceptable level and meeting the requirements for clinical competence for that PGY year.

It is the intent of the Otolaryngology program to develop physicians clinically competent in the field of Otolaryngology. Physicians completing the program will be eligible for certification by the American Board of Otolaryngology with a goal of a 100% pass rate on this examination.
Clinical competence requires:

1. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. [as further specified by the Review Committee and/or program]
2. **Medical Knowledge** about established and evolving biomedical, clinical, and epidemiological and social-behavioral sciences and the application of this knowledge to patient care. [as further specified by the Review Committee and/or program]
3. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and continuous improvement in patient care based on self-evaluation and life-long learning. [as further specified by the Review Committee and/or program]
4. **Interpersonal and Communication Skills** that result in effective exchange of information and collaboration with patients, their families, and other health professionals. [as further specified by the Review Committee and/or program]
5. **Professionalism** as manifested through a commitment to carrying out professional responsibilities and an adherence to ethical principles. [as further specified by the Review Committee and/or program]
6. **Systems-Based Practice** as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide optimal health care. [as further specified by the Review Committee and/or program]
7. Demonstration of satisfactory of specialty surgical skills

**Evaluation and Promotion**

During the residency period, the above elements of clinical competence will be assessed in writing in a timely manner during each rotation or similar educational assignment by direct faculty supervisors with subsequent review by the Program Director. These evaluations must document progressive resident performance improvement appropriate to the educational level, and the program will use multiple evaluators (e.g., faculty, peers, patients, self, and other professional staff) to evaluate the resident. A resident will meet with the Program Director, Associate Program Director and the Department Chair twice a year to review results of evaluations, in-service scores, pt satisfaction evaluations, Key Indicator Logs, Resident Operative Progress Evaluation (R.O.P.E.) and conference attendance, completion of administrative duties and overall performance for their level of training. A summary of the semi-annual evaluation meeting will be reviewed and signed by the resident. The evaluations will be maintained in confidential files and only available to authorized personnel. Upon request, the resident may review his/her evaluation file at any time during the year.

Reappointment and promotion to a subsequent year of training require satisfactory ratings on these evaluations and

- Competency with surgical skills in their pg year
- Medical Knowledge based on faculty evaluations
- Scoring at or above their expected level of training on their faculty evaluations of the core competencies

Page 139
Updated: 11/21/2014
A resident receiving unsatisfactory evaluations during the year will be reviewed by the Program Director, counseled, and written recommendations made to him/her may include but are not exclusive to:

1. specific corrective actions
2. repeating a rotation
3. academic warning status or probation
4. suspension or dismissal, if prior corrective action, academic warning and/or probation has been unsuccessful.

In instances where a resident’s agreement will not be renewed, or when a resident will not be promoted to the next level of training, the program director will provide the resident with a written notice of intent no later than four months prior to the end of the residents’ current agreement. If the primary reason(s) for the non-renewal or non-promotion occurs within the four months prior to the end of the agreement, the program director will provides the resident with as much written notice of the intent not to renew or not to promote as circumstances will reasonably allow, prior to the end of the agreement.

The resident may appeal an unsatisfactory evaluation by submitting a written request to appear before the department’s Resident Education Committee in a meeting called by the Program Director. The Committee reviews a summary of the deficiencies of the resident, and the resident has the opportunity to explain or refute the unsatisfactory evaluation. After review, the decision of this Committee is final.

At the completion of the residency program the Program Director prepares a summative evaluation which documents the resident’s performance during the final period of education and verifies that the resident “has demonstrated sufficient competence to enter practice without direct supervision”. This evaluation is accessible for review by the resident and remains in the program’s files to substantiate future judgments in hospital credentialing, board certification, agency licensing, and in the actions of other bodies.
Subject: Hand Off Policy

Purpose: To establish a procedure by which the on call resident(s) can accurately and timely hand off information regarding the inpatient service at each of the affiliated hospitals to the designated resident to the designated resident in the Department of Otolaryngology – Head and Neck Surgery Residency Programs.

Date Developed: April 2012

Responsible Party: Chairman / Program Director

Compliments:

Policy
Each residency program must have a written procedure by which residents are guided on the process to handoff pertinent information regarding the in-patient service to the appropriate resident.

Procedure
The residents of the Department of Otolaryngology at the University of Arkansas for Medical Sciences (UAMS) provide call coverage for three separate hospitals (UAMS, ACH, CAVHS) nightly, weekends and holidays. For each call there will be a designated first call resident and a second call upper level resident on duty. Both residents take “at home” call.

Evening Hand Off
The chief resident for each location will call the first call resident detailing all new consults and admissions to the ENT service. In addition a secure e-mail containing relevant information will be sent to the On Call Resident(s) and to the Program Coordinator (for documentation purposes).
Morning Hand Off
BY the start of the following workday the on call resident (first call from the previous night) will contact (by phone and secure email) the Chief Resident at each affiliated hospital detailing all new consults and admissions to their service. The program coordinator will be included on the e-mail

Policy Review and Revisions

This policy will be reviewed by the Resident Education Committee (REC) at least annually for necessary changes.
Subject: Resident Vacation, Travel and Leave Policy

Purpose: To establish guidelines of vacation, leave of absence, travel and leave for professional development of the otolaryngology resident while maintaining the financial viability of the department.

Date Developed: August 29, 2005

Updated: May 2012

Responsible Party: Program Director / Associate Program Director / Dept. Chairman


Purpose
To establish guidelines of vacation, leave of absence, travel and leave for the professional development of the otolaryngology resident while maintaining the financial viability of the department.

Policy
Leaves of absence and vacation may be granted to residents at the discretion of the Program Director in accordance to departmental, national, and institutional policy. According to the American Board of Otolaryngology (ABOto), and stipulated by the Accreditation Council for Graduate Medical Education (ACGME), the total of any single resident leave and vacation may not exceed six weeks in one year. If a circumstance occurs in which a resident absence exceeds the six weeks per year outlined by the ABOto, the program director must submit a plan to the ABOto for approval on how the training will be made up which may require an extension of the residency. Assured funding for the resident’s stipend is not guaranteed if extended time in the program is needed. Residents are strongly encouraged to review all of the certification requirements which can be found at www.aboto.org.

The department must also be compliant with the resident leave policy of the University of Arkansas for Medical Sciences (UAMS) as outlined below and on the following UAMS website; http://www.uams.edu/gme/benefits.htm.
**Vacations:** Residents receive 21 days (only 15 workdays i.e. M-F may be taken) of paid vacation each year. This cannot be "carried over" from one year to the next. Each program will inform its residents/fellows of the specialty Board regulation on leave used vs. Board eligibility.

**Professional Leave:** This leave is determined by the individual department. However, time spent attending professional meetings or taking board examinations or other examinations is not counted as vacation if the activity is approved by the Program Director.

**Sick Leave:** Residents have 12 days of sick leave for medical reasons during each year of training. Each program will inform its residents/fellows of the specialty Board regulation on leave used vs. Board eligibility. The sick leave cannot be "carried over." Sick leave in excess of 12 days requires special review by the Associate Dean and Program Director.

Thus, of these 6 weeks (42 days), The Leave Policy through the Department of Otolaryngology Head and Neck Surgery at the University of Arkansas for Medical Sciences allows PGY 2-5’s: 3 weeks (15 days, Monday-Friday) for vacation and allows a maximum of 2 weeks (10 business days, Monday-Friday) to be used to attend meetings and 12 days of sick leave, PGY 1’s receive 3 weeks (21 days, Sunday-Saturday) for vacation and 12 days of sick leave.

**Specific guidelines**

**A. Vacation**
1. PGY 2-5 Residents will be allowed 3 weeks of vacation counted as 15 business days (Monday-Friday) per academic year and will be counted against the 42 days or 6 weeks away from the residents learning environment. Weekend days are not counted as vacation.
2. PGY 1 Residents will be allowed 3 weeks of vacation counted as 15 weekdays and 6 weekend days.
3. Residents are not allowed to take any of their weeks of vacation back to back without special approval from the Program Director.
4. Single vacation days are only given as an *extreme exception* and must be approved by the Program Director.
5. No more than 2 residents will be allowed to take vacation at the same time while rotating on the same assigned service (pediatric and otology, UAMS, Veterans Administration).
6. Residents are discouraged from taking vacation during rotations where there are only 2 residents on a particular rotation.
7. **The Resident is responsible for completing and submitting a hard copy of their leave form to the Residency Program Coordinator who will then submit the request to the Program Director for approval consideration**
8. All vacation requests must be approved by the Residency Program Director and when applicable the Associate Residency Director.
9. According to ACGME and UAMS policy vacation time does not accrue from year to year and must be scheduled and taken in the same academic year the vacation is earned. Residents are not paid unused vacation leave at the time of the completion of their program.

**B. Interviews**
1. PGY5 and PGY4 residents will be allowed up to 10 business days (Monday-Friday) travel time for interview. These are considered professional days and *compete* with those used for educational purposes. This time will count in the 6 weeks (42 days) allotted for the fiscal year. The 10 days are the total time allotted during the PGY5 and PGY4 academic fiscal years, not per interview. **If these 10 days have been exhausted by educational and interview days then the residents must use vacation time for additional interviews.**
2. It is the resident’s responsibility to submit a leave request at least 1 month in advance of the leave time requested for interviews. However special circumstance may apply in the event an interview is granted and will occur in less than one month of notice.
3. It is the resident’s responsibility to turn in a hard copy of their leave form to the Residency Program Coordinator who will obtain approval or not approved from the Residency Program Director and Chairman.
4. All interview requests must be approved by the Chairman, Residency Program Director or Associate Director when applicable. Chairman should be informed of planned interviews.

C. PGY-5 End of Year Allowance
1. PGY-5 residents will be given the last 5 business days of June for moving, etc but must count against the 15 days of vacation or 10 educational days allotted for the year.
2. PGY-5 residents will not be allowed to take a week of vacation prior to the last week of June (There will be no exceptions to this).

D. Outside Meetings
1. Each resident will be allowed to attend major courses or meetings during their residency, as approved by the Residency Director and the Department Chairman. Leave for these events must comply with the leave policy outlined in A-C.
2. A resident who is accepted to present a scientific paper at major meeting must notify the Program Director and the request for travel will be submitted for consideration and approval. Approval of such travel will be at the Discretion of the Program Director and Department Chairman. If approved for travel, ALL travel plans and projected travel costs must be approved by the Program Director and Department Chairman PRIOR TO being made by the resident. Coverage for clinics and OR must be planned ahead and approved by the Faculty Chief at the hospital at which the resident is assigned at the time of the meeting.

E. Presentations
1. Podium presentation may be sponsored by the department each fiscal year at the discretion of the Department Chair.
2. A poster presentation may be considered and will be reviewed by the Residency Director and Department Chair.
3. For both podium and poster presentations to be considered, the meeting must be a substantial national meeting in the field of otolaryngology and must contribute to the national/international recognition of the resident member and department and all other methods of sponsorship have been exhausted, as determined by Chairman and/or Residency Director.
4. These requests must be submitted at least six to eight weeks prior to the date of conference for review. Reservations may not be booked before receiving approval, as the department will not pay for cancellation fees. There will be no exceptions to this rule.
5. All presentations financially sponsored by the department must be submitted for publication at the time of the meeting. Failure to submit for publication will result in forfeiture of future department sponsorship of travel.
6. Un-sponsored travel for scientific presentations may be supported by available resident book funds.
7. Leave for presentations must comply with the number of days allotted for educational activities (10) each year. Vacation may need to be used if the number of days to scientific meetings and other related educational activities exceeds 10 days.

F. General Guidelines
1. PGY3 residents are approved to attend the Annual Meeting of the American Academy of Otolaryngology (AAO) - Head and Neck Surgery each academic year. These residents are expected to attend educational activities, presentations, or courses or this privilege may be revoked by the department for future residents.
2. Residents are responsible for all travel arrangements for the AAO meeting and other scientific programs.
3. Residents are responsible to turn all travel information in to the Program Coordinator to the residency program 6-8 weeks prior to travel so that a proper Travel Authorization can be turned in to the desk of the travel liaison in our department.
4. Most reimbursements for travel will take place only after the resident has returned from their conference.
5. Resident is responsible to turn in all receipts to the Program Coordinator to the residency program for processing.
6. Residents are responsible for cancellation of any travel arrangements and agreements.
7. Any travel agreements or arrangements paid by the department (as a special exception) and that are not cancelled in a timely manner prior to the conference/meeting will be deducted from the resident’s bookfund account.
8. No first class airfares, unless a free upgrade is awarded.
9. Travel expenses will only be allowed the day before and after the official start and end dates of the meeting, per UAMS policy.
10. No reimbursement for spousal travel (airfare, meals, etc.).
11. Hotel will only be reimbursed at the rate equal to or less than the conference hotel (exceptions must be approved by the Chair).
12. Department will review airline fare vs. mileage with personal vehicle travel requests. The lower of the two will be chosen.
13. Meals are reimbursed at the State of Arkansas per diem rates.
14. Rental cars will only be considered for reimbursement if the cost for the rental car is less than the cost of taxi/shuttle to and from the conference hotel. Rental cars will not be reimbursed if traveler chooses to stay at a hotel other than the conference hotel UNLESS the costs of the hotel and rental car are less than the cost of the conference hotel. Rental cars will not be reimbursed for personal use while at a conference.
15. Valet parking will not be reimbursed. Parking for a rental car will only be reimbursed if the rental car expense is justified (see above).
16. Telephone calls and internet services will be reimbursed for business purposes only.
17. No late registration fees will be paid.
18. No airline change fees will be paid unless the change is due to a department related event.
19. If the travel was sponsored and paid for by another agency/company, the traveler cannot request reimbursement from any fund belonging to UAMS/ACH for that same travel. Money from external sponsors should be routed through the department and placed into the resident’s educational fund for use.
20. All travel grants must be disclosed to the residency coordinator so that this may be noted on all travel authorization forms prior to travel.

G. Sick Leave

1. Sick Leave for medical reasons will be granted with pay for a maximum of 12 days during each year of the residency program. Weekdays and weekend days during which the resident is assigned to work will be charged as sick leave if the resident is unable to work due to illness. Sick leave cannot be carried over from one year to the next, nor will residents receive payment for unused sick leave at the completion of the program.
2. Residents wishing to access sick leave must be approved by the staff whom the resident is on service with.
3. Residents must notify the Residency Program Coordinator immediately when accessing sick leave where this information can be documented and monitored. All sick leave information is then relayed to the Program Director and/or Associate Director.
4. Residents are asked to use discretion when taking sick leave. Residents are to be reminded of the impact on other residents in the program, faculty and patient care.
5. According to the American Board of Otolaryngology an excess of six weeks (beyond the allowed three weeks of vacation) of time lost in this manner, must be made up before the
College of Medicine can issue a certificate indicating satisfactory completion of internship or residency requirement.

6. Residents may be placed on sick leave for extended periods of time with the approval of the Program Director, according to the Policy of the Graduate Medical Education Committee regarding resident leave.

**Medical Mission Trips for Residents**

In an effort to encourage resident participation in medical missions as well as provide an important educational opportunity, these guidelines for resident mission trips are suggested. Several faculty who participate in missions would serve as mentors on a given trip, and selection for a trip would depend not only on resident interest but also on the technical ability of the resident due to the fact that on these trips the resident will frequently be asked to operate independently.

Guidelines:

1) Senior Residents (PGY4-5)/Fellows would be given priority.
2) Resident/Fellow must express interest as well as a level of competency/technical ability that would allow them to function independently on a given trip, which will be at the discretion of the trip advisor.
3) Time off for the trip will be recorded as vacation time up to the maximum allowable time for the resident for that academic year.
4) Resident is responsible to provide funding as necessary for their expenses, but would be encouraged to apply for humanitarian grants.
5) Time away should be limited to a max of 10 working days or less.
6) Resident participation will also be limited by the specific mission organization for the trip and all applications/requirements for that organization must also be met.

**Special Note:**

Any resident who is placed on Academic Remediation or Probation or is under other training restrictions will not necessarily be granted permission to participate in medical mission trips or scientific meetings.

Where specific policies are not stated, GME policy is followed. Please see the University of Arkansas for Medical Sciences, Graduate Medical Education Resident Handbook, [http://www.uams.edu/gme/policies.htm](http://www.uams.edu/gme/policies.htm)
Subject: Moonlighting and Malpractice Insurance Coverage While Moonlighting

Purpose: To define moonlighting, the procedures for approval of moonlighting, and the resident’s responsibility regarding malpractice insurance coverage while moonlighting

Date Developed: November 2004

Updated: October 2011

Responsible Party: Chairman / Program Director


Definition

Moonlighting is defined as any voluntary, compensated professional activity arranged by an individual resident, which is outside the course and scope of the approved residency (includes fellowships) program. For purposes of accreditation, ‘moonlighting’ covered by this policy is ‘external moonlighting’, which is outside the University of Arkansas for Medical Sciences (UAMS) system. (UAMS system includes the participating teaching hospitals.)

Policy

Residents must not be required to moonlight, and PGY-1s are not allowed to moonlight. Because residency education is a full-time endeavor, moonlighting by residents in clinical activities is discouraged. Currently the program does not allow PGY 2 – PGY 5 Residents to moonlight. If a resident decides to moonlight, he/she may do so only with a prospective written statement of permission of his/her Program Director. The Program Director and the individual resident must closely monitor moonlighting to ensure compliance with the 80-hour rule and to ensure it does not interfere with the resident’s ability to achieve the goals and objectives of the educational program.

If a resident is no longer performing satisfactorily in the program, the Program Director may withdraw the permission to “moonlight”. In the event permission to “moonlight” is withdrawn by the Program Director, the obligation to notify an outside employer is the responsibility of the
A resident who established that employment relationship and not the responsibility of the Program Director or the College of Medicine.

Professional liability coverage (malpractice insurance) provided through UAMS is provided only when on official duty and does not cover “moonlighting” activities.

The practice of medicine without a valid medical license is a direct violation of the State of Arkansas Medical Practice Act and could result in criminal charges. The exception to this licensure requirement is outlined in Arkansas Code Annotated Section 17-95-203, which states:

*Nothing herein shall be construed to prohibit or to require a license with respect to any of the following acts:*

(7) *The rendering of services by students, interns, or residents in a licensed and approved hospital having an internship or residency training program approved by the American Medical Association or the State Board of Health or the United States Government;*

It is the responsibility of the clinical facility hiring the resident to moonlight to determine whether such license is in place, adequate liability coverage is provided, and whether the resident has appropriate training and skills to carry out assigned duties.

Residents who 1) moonlight without written approval of the Program Director, or 2) continue to “moonlight” after the permission to do so is withdrawn, or 3) use the University Hospital’s or Arkansas Children’s Hospital’s DEA number while moonlighting will be subject to dismissal from the program.

**Procedure**

In order to be eligible for moonlighting activities, the resident must:

1. Submit a request to moonlight to his/her Program Director.

2. Obtain prospective, written permission from the Program Director. This written permission must be contained in the resident’s file and state the following: “the resident’s performance will be monitored for the effect of moonlighting activities upon performance and that adverse effects may lead to withdrawal of permission.

3. Obtain a valid Arkansas Medical License.

4. Obtain a malpractice insurance policy that will cover the activity to be performed outside the training program, or be certain that the employing facility provides adequate insurance coverage to protect the outside professional activities.

5. Obtain his/her personal DEA number in the event Schedule II drugs are prescribed.
REQUEST TO PARTICIPATE IN MOONLIGHTING ACTIVITIES
For
2014-2015

In order to be eligible for moonlighting activities, the resident/fellow must follow the procedure as outlined in the UAMS College of Medicine GME Committee policy, Moonlighting and Malpractice Insurance Coverage while Moonlighting. Residents/fellows are not required to moonlight. Moonlighting is allowed only with the written permission of the program director upon the resident’s/fellow’s written request to moonlight. This information is contained in the resident’s/fellow’s file. Professional liability coverage (malpractice insurance) provided through UAMS is provided only when on official duty within the training program and does not cover moonlighting activities. Malpractice insurance for such activities is the sole responsibility of the resident/fellow. It is the responsibility of the clinical facility hiring the resident/fellow to determine whether the appropriate credentials, adequate liability coverage and appropriate skill levels are in place.

Moonlighting privileges will be withdrawn if the resident/fellow is no longer performing satisfactorily in the program. In the event permission to moonlight is withdrawn by the program director, the obligation to notify an outside employer is the responsibility of the resident/fellow who established that employment and not the responsibility of the program director or UAMS.

Resident/fellows will be subject to dismissal from the program for the following:

1. Moonlighting without written approval of the program director,
2. Continuing to moonlight after permission to do so is withdrawn,
3. Using the University Hospital’s or Arkansas Children's Hospital DEA number while moonlighting.

As a resident/fellow in the Otolaryngology training program, I understand and will abide by the above requirements for moonlighting activities. I understand that the performance of these activities will not interfere with my ability to achieve the goals and objectives of my training program. Please provide a brief description of these activities.

I request permission to engage in moonlighting activities: ________

I will not engage in moonlighting activities at this time: _____ X _____

Resident Signature Date

Samuel Welch, M.D., Ph.D. Date
Residency Program Director
UAMS, Department of Otolaryngology

Place in Resident’s/Fellow’s file
Subject: Refill of Narcotic Prescriptions Policy

Purpose: To define the policy and procedures for patient care in the refill of narcotic prescriptions by resident physicians (includes fellows) in the Department of Otolaryngology – Head and Neck Surgery Residency Program.

Date Developed: October 21, 2005

Updated: April 3, 2006

Responsible Party: Program Director / Associate Program Director / Dept. Chairman

Compliments: UAMS, GME Policy on Patient Care Activities under the “Residency Program Exemption” to the Arkansas Medical Practices Act, Including Prescribing of Controlled Substances and other Medications, Number 2.600: ACGME Institutional IIID1

Patient prescriptions for narcotic pain medications will not be filled after hours or on the weekend unless you know the patient and their medical history. This policy helps to assure that these potentially addictive drugs are properly monitored. The policy is necessitated by the common practice of those who abuse these drugs of calling for refills after hours when they feel a physician less familiar with their case might handle the request for refills. It is the patient’s responsibility to monitor their supply and use of pain medications so that refill requests can be processed during business hours.

*Where specific policies are not stated, GME policy is followed. Please see the University of Arkansas for Medical Sciences, Graduate Medical Education Resident Handbook, [http://www.uams.edu/gme/policies.htm](http://www.uams.edu/gme/policies.htm).*
Subject: Resident Recruitment, Appointment and Specific Recruitment Criteria

Purpose: To define the specific requirements and procedures for the application, eligibility, selection, and appointment of residents to the Department of Otolaryngology – Head and Neck Surgery Residency Programs, sponsored by the University of Arkansas for Medical Sciences College of Medicine (UAMS-COM).

The UAMS, Department of Otolaryngology-Head and Neck Surgery strongly discourages medical student rotations with our residency program once letters of invitation to interview have been sent out.

Date Developed: November 2004

Updated: October, 2011

Responsible Party: Chairman / Program Director

Compliments: UAMS, GME Policy on Resident Recruitment and Appointment, Number 1.200 ACGME Institutional IIA; Common IA, IIIA

Policy
The recruitment and appointment of residents to the Department of Otolaryngology – Head and Neck Surgery programs sponsored by the UAMS-COM is based on and is in compliance with the institutional, common and specific program requirements of the Accreditation Council for Graduate Medical Education (ACGME). The process of application, eligibility, selection and appointment of residents to this program is the responsibility of the Departmental Chairperson, the Program Director, and/or departmental faculty. This program will not discriminate with regard to sex, race, age, religion, color, national origin, disability, or veteran status.

The written criteria and procedures for resident selection, including a description of the application process is listed below, along with the criteria for eligibility.

I. Application Process
The Otolaryngology Matching Program uses the ERAS – Electronic Residency Application Service for Otolaryngology resident applicants. Specific information about individual programs...
may be obtained from each university. The designated dean's offices at each medical school provide a valuable service to applicants by answering questions and providing other support during the application process. Many schools provide counseling assistance and scores of other services to applicants during this time. Applications are obtained by registering with ERAS at: http://www.aamc.org/students/eras/usemyeras/start.htm

Contact them directly for details.

**American Medical Graduates Contact:**

**Association of American Medical Colleges**  
2450 N Street, NW  
Washington, DC 20037-1126  
Phone: (202) 828-0400  
Fax: (202) 828-1125  
erashelp@aamc.org

**Foreign Medical Graduates**  
**Educational Commission for Foreign Medical Graduates (ECFMG)**  
3624 Market Street Philadelphia  
PA 19104-2685, USA  
Tel: (215) 386-5900  
Fax: (215) 387-9963  
Web: www.ecfmg.org  
E-mail: eras-support@ecfmg.org

With ERAS, your application will be complete when we download it from the ERAS post office. We receive approximately 150 completed applications each year. These are reviewed and invitations to interview are issued to those candidates who seem to be the most competitive on the basis of the application material. Candidates are considered on academic performance, board scores, honors and awards, letters of recommendation, research and work experience, and a well-rounded personal life. The interview is useful to match personalities and interests of candidates with our program. We will interview on two consecutive dates to be determined later. Invitations for the interview sessions will be mailed approximately four weeks prior to the interview date.

We welcome off-campus students to take a senior elective at UAMS, but an elective is not required for selection to the residency program and does not necessarily improve one’s chances. Additionally, an elective does not guarantee automatic selection to interview with our program.

Applicants must apply in the **Fall** prior to the beginning of their first post-graduate year (PGY1). **November 1st is the deadline for applications and determination letters for interviews will be sent out by November 15th.** Interviews will be held in mid to late January of each year. If you are chosen to interview you will be contacted via the ERAS post office by the Program Director.

Please note that the Residency Review Board in Otolaryngology has determined that the PGY1 year be deemed as “categorical.” Therefore, all PGY1 residents that match with our program will begin their otolaryngology residency in the Department of Otolaryngology – Head and Neck Surgery at the University of Arkansas for Medical Sciences, College of Medicine.
II. Eligibility Requirements

A. An applicant must be able to carry out the duties as required of the residency program.

B. An applicant must demonstrate the following English language proficiency to the satisfaction of the Program Director:
1. Proficiency in reading printed and cursive English,
2. Proficiency in writing (printing) English text,
3. Proficiency in understanding spoken English on conversational and medical topics, and
4. Proficiency in speaking English on conversational and medical topics.

C. An applicant must meet one of the following qualifications as established by the ACGME:

1. A graduate of a medical school in the United States or Canada accredited by The Liaison Committee on Medical Education (LCME).
2. A graduate of a college of osteopathic medicine in the United States or Canada accredited by the American Osteopathic Association (AOA).
3. A graduate of a medical school outside the United States who has completed a Fifth Pathway program provided by an LCME-accredited medical school.
4. A graduate of a medical school outside the United States or Canada with one of the following qualifications:
   a. A currently valid certificate from the Education Committee for Foreign Medical Graduates (ECFMG), or
   b. A full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.
5. A graduate who holds a full and unrestricted license to practice medicine in a U.S. licensing jurisdiction.
6. Eligible to be considered for a license in the State of Arkansas in compliance with Arkansas State Medical Board Regulations.

D. An applicant is eligible for appointment only after a negative result on a preemployment drug test as administered by the UAMS Drug Testing Program (UAMS Policy 3.1.14).

E. An applicant must meet all program-specific & GMEC eligibility requirements. These may include, but are not limited to, the following:

1. Application only submitted through the Electronic Resident Application System (ERAS), if available and participation in the National Resident Matching Program (NRMP) or other matching process.
   a. Application deadline: October 15th or unless otherwise designated. Applications received after the deadline may not be considered.
2. Completion of Step 1 on the USMLE board examinations.

III. Selection

The University of Arkansas for Medical Sciences, Department of Otolaryngology – Head and Neck Surgery Residency Program selection includes the criteria and procedures listed below to select residents and the length of time applications are kept on file. Eligible applicants are reviewed by a program selection committee, individual interviews, and/or written interview evaluations. Criteria used for selection may include, but may not be limited to, the following:

A. Review and confirmation of eligibility requirements
B. Performance on standardized medical knowledge tests
C. Overall academic performance in medical school
D. Recent clinical training or experience
E. Demonstrated ability to choose goals and to complete the tasks necessary to achieve those goals
F. Maturity and emotional stability
G. Honesty, integrity, and reliability
H. Lack of history of drug or alcohol abuse
I. Motivation to pursue a career in the selected specialty
J. Prior research and publication experience
K. Verbal and written communication skills (personal statement and interviews)
L. Letters of recommendation from faculty
M. Dean’s letter
N. Medical school transcript
O. The ability to reside continuously in the U.S. for the length of training
P. A commitment to complete the entire training program
Q. Commitment to pursue a career in the selected specialty within the State of Arkansas

IV. Appointment/Registration

Upon verification by the Program Director that an applicant has met eligibility requirements, completed the application process, and been selected according to established criteria, he/she will begin the process of appointment and registration with the UAMS-COM Director of Housestaff Records. An applicant is considered fully appointed and registered in the College and entered into the payroll system in order to receive a stipend only after all the following information has been submitted to the Director of Housestaff Records:

A. Documentation of a negative drug test (UAMS Policy 3.1.14),
B. Verification of successful graduation if previously anticipated. For graduates of US or Canadian medical schools this includes a final official transcript, or letter from The Registrar, or a notarized copy of the diploma. For graduates of medical schools outside the US and Canada, this includes a currently valid ECFMG certificate,
C. All of the following forms (with valid signature):
   1. Resident Agreement of Appointment (contract),
   2. Medical Records Agreement,
   3. Attestation acknowledging receipt of GMEC policies and procedures and Terms and Conditions of Appointment
   4. Confidential Practitioner Health Questionnaire,
   5. Employee Drug Free Awareness Statement,
6. Housestaff Medical Screening Form,
7. Postdoctoral Medical Education Biographical Data Form
8. Long Term Disability Form
9. Acknowledgement of Benefits Policies
10. I-9, State & Federal Tax Forms

D. Copy of a valid VISA (if applicable).
E. Incoming residents/fellows are expected to attend Orientation/Registration in mid-June.
F. All appointments to residency positions are contingent upon successful completion of a criminal background check.

V. Senior Otolaryngology Elective Rotation

A. Applicants participating in a Senior Otolaryngology Elective Rotation with the University of Arkansas for Medical Sciences, Department of Otolaryngology – Head and Neck Surgery are not guaranteed the following:
   a). An interview with our residency program
   b). An appointment to see Dr. Suen or any other faculty.
   c). A recommendation letter from Dr. Suen, faculty, residents or staff.

Where specific policies are not stated, GME policy is followed. Please see the University of Arkansas for Medical Sciences, Graduate Medical Education Resident Handbook, http://www.uams.edu/gme/policies.htm.
Subject: Required Additional Educational Study

Purpose: To define additional educational study for the otolaryngology resident

Date Developed: February 2009

Updated:

Responsible Party: Program Director/Associate Program Director/Dept. Chairman

- **AAO-HNS Continuing Medical Education Home Study Course**
  PGY2-5 residents will participate in the AAO-HNS “Home Study Course.” **One complete set must be completed each year.** Each section must be completed by the deadline date. These scores become part of your file. Participation is monitored and consistent poor performance is addressed by assigning additional reading.

- **Annual Otolaryngology Exam**
  All residents are required to take this exam, usually held on the first Saturday in March. PGY3, 4, and 5 are expected to make 65% or better within their respective year and PGY2 are expected to make 50% or better. Failure to do so will result in a meeting with the program director to discuss causes of low scores as well as possible solutions. Continued performance below our academic standards may be taken into consideration for promotion.
GOALS OF RESIDENT RESEARCH:

1. To provide direct resident experience with scientific inquiry and method with the aim to produce quality research for publication in peer reviewed journals and presentation at national or international scientific meetings.

2. To impart the skills to generate hypothesis, conduct experiments, and acquire data related to otolaryngology practice.

3. To instill the conceptual framework and detail involved in the research process, including the steps necessary to obtain IRB approval, research funding, and manuscript preparation.

4. To provide a clear perception of academic practice and research and how it relates to clinical otolaryngology.

5. To promote the career and success of individual residents through respectable research endeavors while improving the scientific reputation of the Department of Otolaryngology-Head and Surgery at the University of Arkansas for Medical Sciences.
METHODS:

1) Each resident is responsible for completing three (3) research projects during his/her 5 years of residency training. Additional project(s) are encouraged but not required. Elective months for PGY2-PGY5 residents shall be provided by the department to allow focused attention on research projects.

2) Residents shall be mentored by a chosen UAMS-Department of Otolaryngology faculty member for each research project. Faculty member contributions will occur from design to publication. If the project necessitates contribution from a faculty member from another department or specialty (i.e. statistics, pathology, radiology, endocrinology, dermatology etc), the primary mentor will assist in appropriate communication with the third party.

3) Resident research projects are defined as a retrospective chart review, clinical meta-analysis, basic science/benchtop research, animal study, or a prospective clinical trial. Case reports are not included in the definition of a resident research project.

4) All resident research projects are expected to proceed to publication in a peer reviewed journal as well as presentation at an approved national scientific meeting and the UAMS-Department of Otolaryngology annual resident research day.
   a) Because residents are expected to present and publish their research, it remains crucial that residents communicate freely with faculty mentors regarding their projects. If adequate support is not available, residents reserve the right to choose another faculty mentor for their present, or the development of a new, project.
   b) Resident’s projects accepted as first authorship for a national scientific meeting merit financial support from the department to cover travel expenses. However, final disposition regarding departmental financial support is at the discretion of chairman of the department.

5) The resident may either participate in a faculty initiated project or develop their own research under the guidance of a UAMS-Department of Otolaryngology faculty mentor.
   a) If the resident chooses to join an ongoing project initiated by the faculty mentor which is already funded, additional funding application is not required.
   b) If the resident prefers to initiate a new project requiring funding support then submission of a proposal for intramural/extramural grant is required. The resident shall be academically supported by the department to facilitate grant submission. The funding source shall be chosen at the discretion of the resident and his/her faculty mentor. A list
of available intramural or extramural funding agencies will be provided to the residents during the research workshop provided by Office of Grants & Scientific Publications (OGSP).

c) If the project is newly initiated by the resident and his/her faculty member, but has negligible cost to the department (as in retrospective studies); the resident is not required to submit a funding proposal.

d) All projects that require departmental support shall be reviewed by the Clinical Research Committee (CRC) in the Department of Otolaryngology prior project commencement. Residents shall understand that the CRC meets monthly and approval may not be granted for 1-2 months. Revisions requested by the CRC are expected one month following return to the resident.

e) Projects supported by faculty mentors outside the Department of Otolaryngology require approval by the Resident Research Director to assess applicability to the field of otolaryngology and reflection of the department’s goals.

6) If a resident is unable to complete a research project due to faculty mentor issues (i.e. faculty departure, depleted funding, suspended research privileges or other similar unforeseen circumstances) the resident will be given credit for the work they have completed. Every effort by the department will be provided to assist the resident in completion of their research project.

7) If an animal study is to be performed, the residents will complete the necessary course given through the Department of Laboratory Animal Medicine (DLAM) and get certified for laboratory animal handling.

8) Research HIPAA certification is expected to be completed by each resident in their PGY-1 year.

9) If a research project involves human subjects, IRB approval is mandatory (even in retrospective chart reviews). The clinical research coordinator may assist but is not responsible for IRB submissions. However, projects requiring CRC approval may garner additional support by the clinical research coordinator to assist with IRB and CRIMSON submission.

a) Projects approved by the CRC committee require a clinical protocol and informed consent as outlined in standard research practice. This material shall be created by the resident and revised/reviewed by the faculty mentor. IRB contingencies will need to be addressed by the resident and/or faculty mentor.
b) Residents shall understand that IRB approval is outside the control of the department and may take 2 to 8 months depending on the nature of the project (retrospective chart reviews-2 months, prospective clinical studies-8 months)

c) Residents (with faculty support) are responsible for obtaining approval by other research associated committees at UAMS (e.g. biohazard committee, radiation safety committee) when required by their projects.

d) Each resident will be provided 4 months of research time spaced throughout their residency (1 month for PGY-2, 1 month for PGY -3, 1 month for PGY-4 and 1 month for PGY-5).

e) It is at each resident’s and assigned faculty mentor’s discretion on how to spend this allocated research time.

f) However, residents are expected to be on UAMS campus during standard working hours (9-5pm) during their research month if the rare need arises for additional resident support for clinical duties. Rare exceptions need approval by the Resident Research Director.

g) Resident research months do not preclude call duty.

h) To provide residents enough time to complete their projects before the department annual Resident Research Day, no resident will be given a research month later than March, except PGY-2 residents. PGY-2 residents are given a month of research time towards the end of the year to give them enough time to find a research project. However, they will not be held responsible for a presentation on “Resident research day”.

10) Residents may seek assistance from medical students who are interested in research in Otolaryngology. Introduction and approval is required by the faculty mentor involved.

a) The residents will perform an 8 minute presentation of their research projects on “Resident Research Day”. There will be three PGY-3, three PGY-4 and three PGY-5 (total of 9) resident research presentations on “Resident Research Day”.

b) An award will be provided by the department to the residents with be best research conducted that year.

c) Residents may present additional research on “Resident Research Day” which will also hold candidacy for a best research award.

11) The Resident Research Director (presently Emre Vural, MD ) or his support (presently Gresham Richter, MD) shall be available for general research issues, questions, or concerns.

12) Other support staff for research shall include (presently):
a) Ms. Tina Moskow is available for budget and finance related questions during standard working hours.
Subject: Supervision and Fatigue Management

Purpose: To define Supervision and Fatigue Management of the Otolaryngology Resident

Date Developed: November 2006

Updated: October 2011

Responsible Party: Chairman / Program Director

Compliments: UAMS, GME Policy on Supervision 3.100, ACMGE Requirements: Institutional IIIB4; Common VI.C & VID.1-6

Purpose
To define the requirements for supervision and fatigue management of residents.

Policy
In compliance with the University Hospital Rules and Regulations and the UAMS College of Medicine GME Committee policy on supervision, the following provisions apply:

Otolaryngology Residents are under supervision of attending faculty physicians who are members of the active Medical Staff, appropriately credentialed, and will follow the College of Medicine’s Code of Professional Conduct.

Supervision
Residents have reliable systems for communication and interaction with supervisory attending physicians. Residents are supervised in such a way that the resident assumes progressively increasing responsibility according to their level of education, ability and experience. Level of responsibility accorded to each resident is determined by the teaching faculty according to program specific criteria for evaluation and promotion.

On call schedules for attending physicians are structured to ensure that supervision is readily available to residents on duty.

Resident responsibilities are outlined for patient care, documentation and order writing.
DOCUMENTATION OF SUPERVISION OF RESIDENTS at UH, ACH & CAVH:
A. Documentation of all patient encounters must identify the supervising practitioner and indicate the level of involvement. Four types of documentation of resident supervision are allowed:
1. Attending progress note or other entry into the medical record.
2. Attending addendum to the resident’s note.
3. Co-signature by the attending implies that the supervising practitioner has reviewed the resident note, and absent an addendum to the contrary, concurs with the content of the resident note or entry.
4. Resident documentation of attending supervision. (This includes involvement of the attending with a note such as “I have seen and discussed the patient with my supervising practitioner, Dr. ‘X’ and Dr. ‘X’ agrees with my assessment and plan”), at a minimum, the responsible attending should be identified (e.g., “The attending of record for this patient encounter is Dr. ‘X’”).

B. Inpatient Documentation:
1. Inpatient, New Admission: Attending must see and evaluate the patient admission. An attending note or addendum documenting findings and recommendations regarding the treatment plan within one calendar day of admission.
2. Inpatient, Continuing Care: Attending must be personally involved in ongoing care. Any of the 4 types of documentation are required, at a frequency consistent with the patient’s condition and principles of graduated responsibility.
3. Inpatient, intensive care unit (ICU) Care (includes Surgical ICU, Medical ICU, Coronary Care U, etc.): Because of the unstable nature of patients in ICUs, attending involvement is expected on admission and on a daily or more frequent basis. Admission documentation as noted in “Inpatient, New Admissions as well as any of the four types of documentation daily are required.
4. Inpatient, Discharge or Transfer: Attending must be personally involved in decisions to discharge or transfer the patient to another service or level of care (including outpatient care). Documentation requires co-signature of the discharge summary or discharge/transfer note. If patient is transferred from one service to another, the accepting attending should treat the patient as a New Admission.

C. Outpatient Documentation:
1. Outpatient, New Patient Visit: Attending must be physically present in the clinic. Every patient who is new to the facility must be seen by, or discussed with an attending. An independent note, addendum to the resident’s note, or resident note description of attending involvement is required. Co-signature by the attending alone is not sufficient documentation.
2. Outpatient, Return Visit: Attending must be physically present in the clinic. Patients should be seen by or discussed with an attending at a frequency to ensure effective and appropriate treatment. Any of the four types of documentation is required. The attendant’s name must be documented.
3. Outpatient, Discharge: Attending will ensure that discharge from a clinic is appropriate. Documentation requires one of the four types stated previously.

D. Surgery/Operating Room (OR) Procedures: Except in emergencies, attending surgeon should evaluate each patient pre-operatively. A pre-procedural note describing findings, diagnosis, plan for treatment, and/or choice of procedure to be performed (may be done up to 30 days pre-op). Informed consent must be obtained according to policy.
Fatigue Management:

The Otolaryngology Residency program is committed to preventing and counteracting fatigue’s potential negative effects on patient care and learning in this training program. The program director, supervising faculty and Otolaryngology Chiefs monitor the demands of individual rotations and call and make scheduling adjustments as necessary to mitigate excessive service demands and/or fatigue. The GMEC pamphlet on fatigue education is distributed to residents during UAMS orientation to educate them on the signs and symptoms of fatigue.

In the event a resident experiences fatigue severe enough to interfere with his/her ability to function normally or to impair patient care or safety, the resident, another resident or a faculty member will contact the Otolaryngology program director, Associate Program Director or Otolaryngology Chief resident as appropriate. If the Otolaryngology program director is not available, the report may go to the faculty member in charge of the rotation or clinical service.

The resident will nap in the 8th floor sleep room or the Otolaryngology resident lounge (as appropriate) until they can return to their clinical duties or safely drive home. The faculty member, Otolaryngology program director or Otolaryngology Chief Resident who receives the original report of resident fatigue will notify the appropriate chief resident of the service that the resident is on who will arrange coverage if needed. The chief resident will also report the incident to the Otolaryngology program director by telephone or e-mail on in-person, if the program director was not involved in the original report.

RECOGNIZING RESIDENT FATIGUE

David Bienenfeld, M.D., Professor and Vice Chair, Department of Psychiatry, Wright State University School of Medicine

The recent focus by our certifying agencies on resident work hours is only one manifestation of a growing awareness in many sectors of the harmful effects of workplace fatigue on employee performance. In residency training, impaired performance means missed opportunities for learning and, at worst, hazards to patients.

Fatigued residents typically have difficulty with:
- Appreciating a complex situation while avoiding distraction
- Keeping track of the current situation and updating strategies
- Thinking laterally and being innovative
- Assessing risk and/or anticipating consequences
- Maintaining interest in outcome
- Controlling mood and avoiding inappropriate behavior

More specifically, signs of fatigue include:
- Involuntary nodding off
- Waves of sleepiness
- Problems focusing
- Lethargy
- Irritability
Mood lability
Poor coordination
Difficulty with short-term recall
Tardiness or absences at work

**High risk times for fatigue-related symptoms are:**
Midnight to 6:00 AM
Early hours of day shifts
First night shift or call night after a break
Change of service
First 2 to 3 hours of a shift or end of shift
Early in residency or when new to night call
Fatigue can be modeled as the result of forces producing fatigue and forces reversing its effects, i.e. recovery.

**Moves to limit fatigue-related problems include:**
The 80-hour limitation to which our programs are held will certainly help reduce the total number of hours worked.

In general, the residency workload should allow for as little variation in work schedules as is feasible. Rapid or frequent shifts from day to night work are known to increase the risk of fatigue.

Individual residents may need individualized schedules to accommodate idiosyncratic energy cycles.

Many physical illnesses can present as fatigue and should be ruled out when daytime fatigue seems out of proportion to the resident’s workload. The resident should be encouraged to consult his/her primary care physician. Sleep studies may be warranted.

Depression and other psychiatric syndromes may first be manifest as fatigue. Proper diagnosis and treatment should be recommended.
REMOTE ACCESS TO MEDITECH AT ARKANSAS CHILDREN'S HOSPITAL

Residents rotating at the Arkansas Children's Hospital can access their charts for electronic signatures remotely using the following internet access:

http://infocenter.archildrens.org

SECURITY CONTACT INFORMATION FOR ARKANSAS CHILDREN'S HOSPITAL

Should parking be an issue or for general safety concerns, all non-pediatric residents contact security for escorts to and from the parking lots after hours. Below is the contact number for security dispatch – 364-4353.